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QUALITY OF LONG-TERM CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

APRIL 28, 1987

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CONTENTS

ADMINISTRATION WITNESSES

Page

Roper, William L. M.D., administrator, Health Care Financing Administration, U.S. Department of Health and Human Services 46

PUBLIC WITNESSES

Yordy, Karl D., director of division of health care services, Institute of Medicine of the National Academy of Sciences 69

Frank, Barbara W., associate director, National Citizens' Coalition for Nursing Home Reform 84

Johnson, Aaron J., chairman, State Medicaid Directors' Association of the American Public Welfare Association, and Commissioner, Georgia Department of Medical Assistance 93

Willging, Paul, executive vice president, American Health Care Association 108

Blood, Marjory, member, National Legislative Council, American Association of Retired Persons 127

Mootz, Ann, former director, Home Aide Service and United Home Care, on behalf of the National Association for Home Care 139

ADDITIONAL INFORMATION

Press release 1

Opening statement of:
- Senator George J. Mitchell 2
- Senator David Pryor 6
- Senator John Heinz 9
- A report from CRS by Richard Price 12
- A letter from William L. Roper 54

Prepared statement of:
- William L. Roper, M.D 61
- Karl D. Yordy 73
- Barbara Frank 86
- Aaron J. Johnson 95
- Paul R. Willging 110
- Marjory Blood 130
- Ann Mootz 142

COMMUNICATIONS

American College of Gastroenterology 154

American Medical Peer Review Assoc 158

Family Service Association of Indianapolis 173

The National Association of Social Workers (NASW) 176

National Committee to Preserve Social Security and Medicare 186

QUALITY OF LONG-TERM CARE

TUESDAY, APRIL 28, 1987

U.S. SENATE,
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE,
Washington, DC.

The committee was convened, pursuant to notice, at 2:25 p.m. in Room SD-215, Dirksen Senate Office Building, the Honorable George J. Mitchell (chairman) presiding.

Present: Senators Mitchell, Bradley, Pryor, Chafee, and Durenberger.

[The press release announcing the hearing, the prepared written statement of Senators Mitchell, Pryor and Heinz and information on "Quality of Long-Term Care" by Richard Price follow:]

FINANCE SUBCOMMITTEE ON HEALTH TO HOLD HEARING ON QUALITY OF LONG-TERM CARE

WASHINGTON, D.C.—Senator George J. Mitchell (D., Maine), Chairman, announced Monday that the Subcommittee on Health of the Senate Finance Committee will hold the second in a series of hearings on long-term care.

Chairman Mitchell stated that the focus of the hearing will be on the quality of long-term care, and proposals to assure high quality long-term care under the Medicare and Medicaid programs. The Subcommittee wishes to examine the recommendations of the Institute of Medicine relating to the quality of nursing home care, and to hear from witnesses with respect to the implementation of those recommendations. The Subcommittee will also examine the quality of long-term care provided in settings other than nursing homes.

The hearing will be held on Tuesday, April 28, 1987 at 10:00 a.m. in room SD-215 of the Dirksen Senate Office Building.

OPENING STATEMENT

HEALTH SUBCOMMITTEE - SENATE FINANCE COMMITTEE

APRIL 28, 1987

SEN GEORGE J. MITCHELL

On behalf of the Subcommittee on Health, I would like to welcome you to the second in our series of hearings focusing on long term care. Today we will examine recommendations and suggestions for ways in which the Federal Government might help to ensure a high quality of care for the 1.5 million Americans who reside in nursing homes and the additional millions who depend on home care services.

While it is appropriate that we focus on the problems, it is also important to note that there are large numbers of very dedicated individuals who provide care for our disabled and frail elderly population. I am pleased that nursing homes and home care agencies in Maine are consistently above average in quality of care. However we have a considerable body of evidence that indicates that there are serious problems with the quality of care for chronic illness in many areas of this country.

Congress, in 1985, requested that the Institute of Medicine conduct a study of the quality of care in nursing homes that would provide a careful review of the issues and suggest appropriate actions. The Institute's study group not only reviewed existing studies, but held public hearings and conducted field interviews with experts in many states. Their report, received in April 1986, clearly documents a number of reliable studies that indicate an inadequate level of care in a significant number of nursing homes.

The recommendations of the Institute of Medicine have been extensively reviewed and discussed over the past year. Most notable is the work of a coalition of industry representatives, organizations representing health care professionals and nursing home employees, and consumer advocates. This group, led by the National Citizens Coalition for Nursing Home Reform, is to be congratulated on their long and difficult efforts in reaching a consensus on most of the more difficult issues. They have extended the work of the Institute of Medicine in a significant and useful way.

I would also like to note the outstanding work of my colleague Sen Heinz, in bringing the problem to the attention of the Congress in the past and in introducing legislation in this area in the last Congress. Unfortunately, he is unable to be with us today, as he was called away on personal business related to the recent death of his father.

Building on those past efforts, I am pleased to announce that today I will, with Sen Pryor and Sen Bradley, introduce legislation that includes many of the suggestions of the Institute, the Coalition and which builds on prior legislation in this area. The bill includes provisions that will ensure adequate professional staffing, training for nursing aides, mandates quality assessment and assurance activities in nursing homes, and sets standards for survey and certification procedures.

The bill also calls for the creation of a National Commission on Long Term Care. This Commission, with broad representation from consumer, industry and health care workers is essential to address remaining problems of ensuring access, providing a more sensible system of reimbursement, and providing for an ongoing forum for monitoring quality of care in both nursing home and in home care.

Up until now, very little attention has been paid at the federal level on the quality of care that home health agencies provide. In the past, home health agencies were generally free of quality problems, partly because the field was comparatively small.

According to the National Association for HomeCare, since the enactment of Medicare and Medicaid in 1965 there have been less than a dozen convictions of home care providers for fraud.

We must be assured that this good record continues. Last week I joined with Senator Bradley and others in introducing the Medicare Home Health Services Improvement Act of 1987, which includes a provision to assure quality of care in the delivery of home health services under Medicare.

I look forward to the testimony to be presented by the witnesses today on the quality of care provided to the nation's elderly in long term care facilities. We must work together to assure that Medicare and Medicaid beneficiaries receiving nursing home and home health services receive the highest quality care available and are protected from substandard care that may jeopardize their health and well-being.

OPENING STATEMENT OF SENATOR DAVID PRYOR

at a hearing on

QUALITY OF LONG TERM CARE

Senate Finance Committee/Subcommittee on Health

SD 215 Tuesday

2:00 p.m. April 28, 1987

Mr. Chairman, I am pleased to be here today as the Subcommittee on Health holds this hearing on a most important topic -- that of the quality of long term health care provided under the Medicare and Medicaid programs.

As we are all aware, the major portion of the health care discussions going on this year are centered on catastrophic health care coverage. The effort being directed toward solving a number of the health care coverage gaps is laudable -- and it is clear that we will see some legislation enacted this year to fill at least some of those gaps.

However, I believe it is just as important (or even more so) that we make certain that the care being provided under our federal health care programs is adequate and appropriate. This is particularly true of the care delivered to some of our most frail and vulnerable elderly -- those individuals confined to their homes and those senior citizens who reside in nursing homes.

Mr. Chairman, as you may know, my interest in quality health care for the elderly, especially the quality of care provided in nursing homes, goes back almost 20 years to my days in the House of Representatives. Since that time there has been a great deal of activity in this area, but I think we have never had more cause to hope for meaningful reform with respect to home delivered and nursing home care.

Last Wednesday I joined with Senator Bradley, you, and a number of our colleagues in sponsoring legislation which would clarify the home health care benefit under the Medicare program. The legislation includes changes which a number of us have worked for during the last few Congresses with minimal success. In addition the legislation proposes an important first step toward establishing a quality control mechanism for home health care.

On Friday I hosted a briefing for Congressional staff on issues related to the quality of care in nursing homes. At the meeting, which was organized by the National Citizens' Coalition for Nursing Home Reform, positions on 12 major nursing home reform issues were presented by representatives of 20 organizations which have been working for the past year to develop a consensus reform package. The final positions were endorsed (in one form or another) by almost 50 organizations. I have never been more hopeful that meaningful changes in this area were within reach, and I think all of the groups who were involved with the effort deserve much credit for the willingness to participate in the process. That willingness has made all the difference.

Finally, today, Mr. Chairman, I have joined with you in introducing the "Medicare and Medicaid Nursing Home Quality Care Amendments of 1987", legislation which builds on the recommendations of the Institute of Medicine nursing home quality report issued last year and the efforts of this committee last fall to enact nursing home quality legislation. I look forward to a full committee discussion of this legislation in the coming months.

In summary, this last week has been a significant one in the area of quality of care reform for our federal health care programs. As I have said, I am much encouraged by the movement we have seen, and I am proud to be a part of these efforts. I look forward to the testimony of our witnesses today as well as full committee action on quality of care reform in the home health and nursing home care areas.

Opening Statement of
Senator John Heinz
Senate Finance Committee, Subcommittee on Health
Hearing on Quality of Long Term Care
Tuesday, April 28, 1987

Mr. Chairman, I am submitting this statement for the record to commend you for calling this hearing on a subject that affects the lives of millions of elderly Americans, the quality of long term care.

Today, the Subcommittee will be considering proposals to assure the highest quality long term care under the Medicare and Medicaid programs, and will be examining the recommendations of the Institute of Medicine relating to the quality of nursing home care. In the next couple of months, new studies and data I have requested may suggest the need for additional action by this body. I look forward to working with you, Mr. Chairman, to find ways to further improve nurse staffing, and to toughen our stance towards those who would violate minimum health and safety standards designed to protect our most vulnerable citizens.

In May 1982, HCFA proposed changes in regulation of nursing homes that would have eased annual inspection and certification requirements. The proposed de-regulation of nursing homes was met with a storm of public protest. The Senate Special Committee on Aging, which I chaired at that time, held hearings which revealed the de-regulation proposals were ill-advised. Congress subsequently blocked implementation of these proposed rules, and mandated a special Institute of Medicine study to determine the appropriate role of the regulatory process in ensuring high quality nursing home care.

In 1984, while chairman of the Senate Special Committee on Aging, I directed the staff to conduct a two-year investigation of problems related to quality, cost and access to long-term care for our nation's elderly.

The Committee's investigation revealed numerous problems with the quality of services provided to nursing home residents, discrimination against the impoverished on Medicaid, and enormous cost burdens which bankrupt all but the wealthiest in nursing homes. Evidence of this crushing burden is the fact that as many as half of all Medicaid supported nursing home residents were admitted to facilities as private paying patients.

Our investigation made it all too clear that Federal and State governments have not fulfilled their responsibility to ensure that nursing home residents are provided proper care. While we have come a long way in improving the physical facilities in nursing homes, we have only scratched the surface when it comes to ensuring high quality care. Thousands of patients still suffer from physical and mental abuse, poor nutrition, inadequate nursing care and general neglect that we hoped had been corrected long ago.

We found that existing Federal and State enforcement policies are so lacking that in 1984 and 1985 over one third of the nation's skilled nursing facilities -- those certified to care for the sickest patients -- failed to comply with the most essential health, safety and quality standards of care. Nearly a thousand of these homes fail to meet the basic standards year after year, providing clear evidence that monitoring is lax and existing sanctions are ineffective.

The Committee investigation also found that low income elderly have difficulty in obtaining access to nursing home services. We learned, not surprisingly, that under the current Medicaid reimbursement system the poorest patients with the greatest health needs faced the most insurmountable barriers in gaining access to nursing home care. As a result, thousands of impoverished elderly are unable to find a nursing home bed. With the millstone of Medicaid around their neck, these low income elderly are subjected to stringent pre-admission screening and are told that the home simply cannot afford to accept them. Private pay patients go to the head of the line because they can be charged more even if they need less care.

Mr. Chairman, I am troubled by reports that some State Medicaid programs are inadequately reimbursing nursing homes, in violation of Federal law. The General Accounting Office has reported that the Federal government has done little to enforce statutory assurances that reimbursement be adequate for high quality care. As a result, some nursing homes have strong incentives to cut corners, including hiring untrained or inadequately trained staff, and providing inadequate supervision by registered nurses. At the same time, elderly patients are being discharged quicker and sicker from hospitals to nursing homes. This has shifted the burden of sub-acute care to long term care facilities, requiring these facilities to give a level of care for which they are no longer adequately staffed and reimbursed. These conflicting trends strongly suggest the need for improved Federal attention to nursing home reimbursement.

Mr. Chairman, I am pleased to join you and others in sponsoring the Nursing Home Quality Act of 1987. This bill has been carefully worked out with the nursing home industry and consumer advocates. I am pleased that this bill incorporates most of the key provisions from legislation I introduced last year. To avoid unnecessary duplication of effort and recognizing that the coalition of groups working on this issue have come a long way in the past six months, I am not planning to reintroduce my own comprehensive bill this year. As new research on this subject becomes available, however, I may offer additional language addressing problems with enforcement of standards, access to care, and nursing services. I am developing specific proposals on these issues that I hope we can address in subsequent hearings and during mark-up of this bill in the Finance Committee.

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April 23, 1987

TO : Senate Committee on Finance
Attention: Bruce Kelly

FROM : Richard Price
Specialist in Social Legislation
Education and Public Welfare Division

SUBJECT : Information on Quality of Long-Term Care

The following responds to your request for a discussion of information on the quality of long-term care services, and specifically (1) the Institute of Medicine's (IOM) Report on Improving the Quality of Care in Nursing Homes, and (2) quality of home health care under Medicare and Medicaid. The first four sections of this report are devoted to the IOM report and the final section discusses home health care.

INTRODUCTORY DISCUSSION OF THE INSTITUTE OF MEDICINE'S REPORT ON NURSING HOMES

In the summer of 1983, the Health Care Financing Administration (HCFA) asked the IOM, a component of the National Academy of Sciences, to undertake a comprehensive study of nursing home regulations that apply to facilities participating in Medicare and Medicaid and to make recommendations on any changes that should be made to assure quality of care provided by these institutions. This study was requested following controversy generated by regulations proposed by HCFA in 1982 to revise regulatory requirements for nursing homes. Among other things, the proposed changes would have eased the annual inspection and certification requirements for facilities with a good record of compliance, and would have authorized States, if they wished, to accept accreditation of nursing homes by the Joint Commission on Accreditation of Hospitals (JCAH) in lieu of State inspections as a basis for certifying nursing homes as meeting Federal requirements for participation in Medicare and Medicaid. Following their publication, Congress twice enacted legislation prohibiting the Secretary of Health and Human Services from implementing these regulations.

The IOM report, Improving the Quality of Care in Nursing Homes, was published early in 1986 and contains recommendations for revising and expanding current statutory and regulatory requirments for nursing homes wishing to participate in Medicare and Medicaid. The IOM found that the quality of care and quality of life in many nursing homes are not satisfactory and that more effective government regulation can substantially improve quality in nursing homes. To accomplish this, IOM recommends (1) specific changes in the standards of care which nursing homes must meet in order to participate in Medicare and Medicaid; (2) measures to strengthen the process of determining the extent to which nursing homes are complying with standards for providing quality care; and (3) improvements in enforcing compliance with Federal standards.

Following the publication of this report, several bills whose provisions embodied many of the IOM's recommendations were introduced into the 99th Congress. H.R. 1868, reported by the Committee on Finance on September 10, 1986, but never voted on by the full Senate, contained certain provisions similar to the IOM recommendations. While the IOM report has received broad support from both nursing home associations and patient advocates' groups, certain of its recommendations were the subject of discussion and debate. In addition, other questions arose over the extent to which legislation is necessary to implement IOM recommendations. HCFA has stated that many of

IOM's recommendations can be included in revised regulations. HCFA expects to publish proposed rules that will revise Medicare and Medicaid nursing home regulations according to certain IOM recommendations in May 1987.

The following sections summarize major recommendations of the IOM report and provide background information about current law and policy as well as a discussion of some of the issues that arise from the recommendations.

I. CHANGES IN THE FEDERAL CERTIFICATION REQUIREMENTS FOR NURSING HOMES

A. Current Law and Policy

In order to be certified to participate in Medicare and Medicaid, skilled nursing facilities (SNFs) must meet certain requirements contained in section 1861(j) of Medicare and in regulations at 42 CFR part 405, subpart K, often referred to as conditions of participation. These requirements detail standards of staffing, organization, and health and safety which SNFs must comply with in order to receive Medicare and/or Medicaid reimbursement.

At their option, States may also cover in their Medicaid plans intermediate care facility (ICF) services. Medicaid law defines an ICF as an institution which is licensed under State law to provide on a regular basis health-related care and services to individuals who do not require the degree of care and treatment provided by hospitals or SNFs but who because of their mental or physical condition require care above the level of room and board that can be made available to them only through institutional facilities. ICFs must also meet (1) standards prescribed by the Secretary for the proper provision of care, (2) standards of safety and sanitation established by the Secretary in addition to those applicable to nursing homes under State law, and (3) requirements for protecting patients' personal funds. Standards for ICFs have been published by the Secretary in regulations at 42 CFR part 442, subpart F. These regulations were first published in 1974 and have not been substantively revised since 1978.

B. Major Recommendations of the IOM Report on Federal Certification Requirements

The IOM report included the following major recommendations on Federal certification requirements for nursing homes seeking to participate in Medicare and/or Medicaid:

1. The regulatory distinction between SNFs and ICFs should be abolished. A single set of conditions of participation and standards should be used to certify all nursing homes. The current SNF conditions and standards, with the modifications and additions recommended below, should become the bases for new certifying criteria.

2. A new condition of participation on resident assessment should be added. It should require that in every certified facility a registered nurse who has received appropriate training for the purpose shall be responsible for seeing that accurate assessments of each resident are done upon admission, periodically, and whenever there is a change in resident status. The results should be recorded and retained in a standard format in the resident's medical record.

3. A new condition of participation concerning quality of life should be added to the certification regulations. The condition should state that residents shall be cared for in such a manner and in such an environment as will promote maintenance or enhancement of their quality of life without abridging the safety and rights of other residents.

4. A new condition of participation on quality of care should be added to the certification regulations. It should state that each resident is to receive high-quality care to meet individual physical, mental, and psychosocial needs. The care should be designed to maintain or improve the residents' physical, mental, and emotional well-being.

5. The existing regulation on residents' rights should be made into a condition of participation. The condition should state that every resident has certain civil and personal legal rights that must be honored by the staff of the facility. In cases where the attending physician determines that a legally competent resident is incapable of excercising a right, the conditions and circumstances shall be fully documented in the medical record and the right shall devolve to a responsible party. The following standards should be added to the residents' right condition:

a. All residents admitted to the facility shall be told that there are legal rights for their protection during their stay at the facility and that these are described in an accompanying written statement.

b. Each resident has the right to know the name, address, and phone number of the State survey office, State or local nursing home ombudsman office, and State or local legal service office. The facility shall post such information in a location accessible to residents and visitors.

c. Each resident has a right to see written facility policies. Facilities shall make policies available on request. Facilities shall post State survey reports and plans of correction in a location accessible to residents.

d. Each resident may inspect his/her medical and social records upon request to the facility.

e. Each resident must receive prior notice of transfer, discharge, and expiration of reserve bed days when a resident requires hospitalilization, for example.

f. Each resident, along with his/her family has the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies.

g. Each resident has the right to meet with visitors and participate in social, religious, and political activities at their discretion so long as the activities do not infringe on the rights of other residents. This includes the right to join others within and outside the facility to work for improvement in long-term care.

6. A new condition of participation entitled "Adminstration" should be established, with certain existing conditions of participation reclassified as standards under this new condition.

A new standard, nurse's aide training, should be added to the administration condition. The standard should require that all nurse's aides complete a preservice State-approved training program in a State-accredited institution such as a community college.

Other new standards that should be added to the administration condition include a prohibition against having different standards of admission, transfer, discharge, and service for individuals on the basis of sources of payment.

Facilities should also develop and implement a plan for regular resident participation in decision-making in the facility's operations and policies and for presentation of resident concerns.

In addition, certified nursing homes should be required to permit access to the homes by an ombudsman (whether volunteer or paid) who has been certified by the State. With permission of a resident or legal guardian, a certified ombudsman should be allowed to examine the resident's records maintained by the nursing home. Any authorized employee or agent of a public agency, or any authorized representative of a community legal services organization, or any authorized member of a non-profit community support agency that provides health or social services to nursing home residents should be permitted access at reasonable hours to any individual resident of any nursing home.

7. The present social service condition should be changed to require that each facility with 100 beds or more be required to employ at least one full-time social worker.

C. Discussion of Selected Issues Arising from IOM Report Recommendations on Federal Certification Requirements

As IOM points out, SNFs are considered more medically oriented nursing homes, as implied by the use of the term "patients" throughout SNF regulations. ICFs, on the other hand, provide health-related care and services and regulations refer to "residents." One of the main differences between SNF and ICF standards is the requirement for minimum numbers of licensed practical nurses and registered nurses. SNFs must have a nurse on duty 24 hours a day, whereas ICFs must have a nurse on duty only during each day-shift.

1. Eliminating the Distinction Between SNFs and ICFs

IOM found, however, that the actual distinctions between SNFs and ICFs is blurred, in the variety of services provided and in the mix of residents they admit with different distributions of disability and nursing care needs. According to IOM, both types of facilities are nursing homes providing a range of services to residents with widely varying service needs. In addition, the definitions of SNFs and ICFs, and especially ICFs, leave a large amount of discretion to the States as to which facilities they will call SNFs and which ICFs. IOM found that some States have almost no SNFs and others have no ICFs. Furthermore, IOM found the mix of characteristics and service needs of the residents found in SNFs in States that have few ICFs do not appear to differ significantly from those found in ICFs in States that have few SNFs.

Both IOM and others point out that eliminating the existing distinctions between SNFs and ICFs and establishing a single set of standards based on stricter SNF requirements would lead to increases in Federal and State Medicaid expenditures because of increased professional nurse staffing required in nursing homes. In addition, certain nursing homes providing ICF care, especially those in rural areas may have difficulties in meeting a 24-hour nursing requirement.

2. Nurses Aide Training Requirement

IOM recommends that nurse's aides be required to complete a preservice State-approved training program in a State-accredited institution such as a community college. The IOM report indicates that over 70 percent of the nursing personnel in long-term care facilities are nurse's aides, and as much as 90 percent of the resident care in nursing homes is delivered by them. In addition, current Medicaid regulations allow nurse's aides to deliver all resident care in ICFs without the supervision of a registered, licensed, or vocational nurse from 3 p.m. to 7 a.m. every day. IOM found that nurse's aides usually are not experienced or adequately trained for their jobs. For these reasons, IOM recommended formal training programs for these nursing home employees.

The nursing home industry has pointed out the economic burden formal training in a State-accredited educational institution might entail for low-paid employees. In addition, they have suggested that on-the-job training might be more appropriate. Others have suggested that on-the-job training should precede the provision of care. The nursing home industry has also questioned whether nursing homes would be required to bear the cost of on-the-job training for aides and whether reimbursement rates would be changed to reflect these costs.

3. Discrimination on the Basis of Source of Payment

IOM noted widespread evidence that nursing homes actively discriminate against two groups: those with heavy care needs and those whose primary source of payment is Medicaid. Nursing homes prefer to admit private-pay residents over public-pay residents because Medicaid reimbursement rates are lower than charges to private-pay residents. IOM notes further that, except in States that have case-mix reimbursement systems, nursing homes have an incentive to select residents with relatively low levels of need over the heavy-care residents because their care is less costly. This is of particular concern to nursing homes because the vast majority of individuals needing long-term care eventually rely on Medicaid for assistance in paying for that care.

IOM recommends that nursing homes participating in Medicaid should be prohibited from having different standards of admission, transfer, discharge, and service for individuals on the basis of sources of payment. The nursing home industry is concerned about the particular form antidiscrimination legislation might take, suggesting that State payments for Medicaid patients are often so low that nursing homes could not remain in business if required to take Medicaid patients without exception.

It should be noted that while the IOM report does not deal with problems of access to Medicare's short-term SNF benefit, numerous studies have pointed to the limited availability of Medicare SNF beds in many areas due to the unwillingness of many nursing homes to participate in the program, and resulting in inadequate access for beneficiaries.

II. MONITORING NURSING HOME PERFORMANCE

A. Current Law and Policy

Section 1864 of Medicare law requires the Secretary to enter into agreements with States to survey nursing homes (skilled nursing facilities) and certify their compliance or noncompliance with Medicare participation requirements. HCFA then makes a determination as to whether it should enter into a provider agreement with the facility to allow the SNF to participate in Medicare.

Similarly, section 1902(a)(33)(B) of Medicaid law requires the State Medicaid agency to contract with the State survey agency used by Medicare (if that agency is the agency responsible for licensing health facilities) to determine whether facilities meet the requirements for participation in the Medicaid program. The State Medicaid agency then decides whether it should enter into a provider agreement with the SNF or ICF in order to allow the facility to participate in and receive reimbursement from the State's Medicaid program.

The survey agency may certify a facility that fully meets requirements and standards for up to 12 months. Survey agencies may also certify a facility for participation if it is found to be deficient in one or more standards if the deficiencies, individually or in combination, do not jeopardize the health and safety of patients and if the facility submits an acceptable plan for correction for achieving compliance within a reasonable period of time.

Medicare law also requires the Secretary to pay States the reasonable cost of performing surveys and certifications. Payments are made according to an annual agreement which HCFA negotiates with each State for performing survey activities. The Medicaid program authorizes a 75 percent Federal matching rate to the States for costs attributable to compensation or training of skilled professional medical personnel and staff supporting such personnel. A portion of Medicaid nursing home survey costs fall into this category. Other survey-related expenditures under Medicaid are reimbursed at the 50 percent Federal matching rate for general administrative costs.

HCFA regional offices also conduct on-site surveys of a sample of facilities to evaluate whether the survey agency has correctly determined continued compliance of the facility with program requirements. These HCFA reviews are referred to as validation surveys in case of Medicare participating facilities, and look-behind surveys in the case of Medicaid facilities. If HCFA finds that such a facility fails to meet program requirements and standards, it is authorized to terminate the facility's participation until the reason for the termination has been removed and there is a reasonable assurance that it will not recur. The Secretary is required to make the results of its validation survey available to State Medicaid agencies and subject to certain limitations, available for public inspection.

State Medicaid agencies are required to conduct at least one "inspection of care" review of all patients annually to determine the appropriateness and quality of care given to recipients. This review is done by a team of nurses and social workers, often with access to physician consultants. Traditionally, this "inspection of care" process has been performed independently of facility surveys in all but a few States. Federal guidelines for inspection of care reviews differ widely in the way they are conducted, the size and qualifications of the inspection teams, and the scope of review.

B. Major Recommendations of the IOM Report on Monitoring Nursing Home Performance

The IOM makes the following recommendations on monitoring nursing home compliance with Medicare and Medicaid requirements for certification:

1. Medicare and Medicaid survey and certification process requirements should be consolidated in one place in the Code of Federal Regulations to promote consistency.

2. The timing of surveys should maximize the element of surprise; the standard annual survey should be conducted somewhere between 9 and 15 months after the previous annual survey, with the average across all facilities within each State remaining at 12 months. Additional standard surveys also should take place whenever there are key events, such as a change in ownership. Independent of the survey cycle, all facilities should be required to pass rigorous life safety code and food inspections at regular intervals.

3. The following two survey instruments and protocols based on the new conditions and standards should be developed:

a. a standard, relatively short survey, that would be resident-centered and use key outcome indicators to determine quality of care, and

b. an extended survey that would entail a comprehensive examination of the nursing home's operations. The extended survey would be used if the standard survey findings indicated that there were, or might be, evidence of inadequacies in the quality of care being provided to some or all of the residents. Good nursing homes would normally experience only the standard survey.

4. Quality assessment in the survey process should rely heavily on interviews with, and observation of, residents and staff, and only secondarily on "paper complicance," such as chart reviews, official policies and procedures manuals, and other indirect measures of actual care given and resident outcomes.

5. HCFA should require States to have a specific procedure and sufficient staff to properly investigate complaints.

6. The survey process should formally seek information directly from consumers (residents and their advocates).

7. In addition to exempting good facilities from extended surveys, ways should be explored to commend superior performance.

8. HCFA should require the State agencies to implement a program to develop and support consistent and reliable surveys. This program should be based on effective training and monitoring of surveyor performance to reduce inconsistency.

9. Title XIX of the Social Security Act should be amended to authorize 100 percent Federal funding of costs of the nursing home survey and certification activities of the States. This authority should be extended for 3 years, after which time a Federal-State matching ratio should be reestablished. HCFA should develop a standard formula for distributing funds to the States under this authority so that each State is funded on an equal basis in proportion to its Federal certification workload.

10. HCFA should revise its guidelines to make them more specific about the qualifications of surveyors and the composition and numbers of survey team staff necessary to conduct adequate resident-centered, outcome-oriented inspections of nursing homes. As a minimum, every survey team should include at

least one nurse. For use on extended surveys, the survey agency should have specialists on staff (or, in small States, as consultants) in the disciplinary areas covered by the conditions and standards (for example, pharmacy, nutrition, social services, and activities).

11. Federal training efforts and support of State-level training programs should be increased, especially during the period of transition to the new survey process, and during the implementation of the new resident assessment condition of participation.

12. HCFA should increase its capabilities to oversee State survey and certification of nursing homes and to enforce Federal requirements on States as well as facilities by: 1) adding enough additional Federal surveyors to each regional office to ensure that the random sample of nursing homes surveyed each year in each State is large enough to allow reasonable inferences about the adequacy of the State's survey and certification activities; 2) scheduling look-behind surveys so that valid comparisons can be made of the findings of Federal and State surveys; and 3) amending title XIX of the Social Security Act to authorize HCFA to withhold a portion of Medicaid matching funds from States that perform inadequately in their survey and certification of nursing homes.

13. The respective roles and responsibilities of the Federal and State Governments should be realigned as follows. The States should be responsible for certifying all Medicare and Medicaid facilities (except State institutions) according to Federal requirements and HCFA should monitor State performance more actively and be responsible for conducting surveys of, and certifying, State-owned institutions directly.

14. The inspection-of-care survey which reviews the quality and appropriateness of care provided to Medicaid recipients should be carried out as part of the new resident-centered, outcome-oriented survey process. But

individual resident reviews should be required for a sample of residents (private-pay as well as Medicaid) rather than for all residents (although individual States may elect to continue 100 percent reviews).

C. Discussion of Selected Issues Arising from IOM Report Recommendations on Monitoring Nursing Home Performance

1. A Resident-Centered Survey Process

IOM recommends that surveys of nursing home compliance with Medicare and Medicaid conditions of participation and standards of care should be based primarily on observation of and interviews with residents and staff, in order to determine the quality of care and services provided. According to IOM, examination of facility records and written procedures should be secondary. In regulations which became effective July 14, 1986, HCFA implemented a new resident-centered, outcome-oriented survey process, referred to as the Long-Term Care Survey process, or the Patient Care and Services (PaCS) survey. These regulations responded to a Federal court order requiring that HCFA publish regulations regarding a survey system that would enable the Secretary to better assess whether high quality care is actually being provided to nursing home patients.

The regulations are intended to replace a survey process which focused on structural requirements (such as written policies and procedures of the nursing home, staff qualifications and functions, a physical plant with particular characteristics) more than on resident outcomes. The regulations are based on a number of demonstration projects and experiments sponsored by HCFA beginning in 1978, and testing and validating of a new survey methodology, commonly referred to as PaCS survey, initially developed in 1982. Under the new survey process implemented in the July 1986 regulations, surveyors are brought face-to-face with residents in a more systematic manner and evaluate resident care through (1) a resident-centered in-depth tour of the facility; (2) observation, interviews, and medical record reviews of a sample of residents; (3) observation of dining and eating assistance; and (4) observation of drug administration.

In the regulations, HCFA indicated that it was responding to the court order, and in large part, to the IOM recommendation for a new resident-centered survey process. Recently, however, the U.S. District Court in Colorado ruled that the regulations did not adequately respond to the court order. In its decision of March 24, 1987, the U.S. District Court cited among other things, the failure of the rule to include the specific procedures to be used in the new survey system, including the guidelines and forms which would constitute the new system. The Court also cited failure of the Secretary to provide an adequate opportunity for comment on the proposed regulations.

The IOM noted in its report a number of problems with PaCS, some of which were addressed at least in part in final HCFA regulations published after the IOM report. Certain other problems, such as the lack of a standard resident assessment requirement and implementing a new survey process without changing conditions and standards for participation, may be addressed in forthcoming HCFA regulations on the IOM report. In addition, HCFA has requested in the FY 1988 budget funding for the development of a resident assessment instrument.

2. Special Medicaid Matching Rates for Survey and Certification

Medicaid authorizes a 75 percent Federal matching rate to the States for costs attributable to compensation or training of skilled professional medical personnel and staff supporting such personnel. A portion of Medicaid nursing home survey costs fall into this category. Other survey-related expenditures under Medicaid are reimbursed at the 50 percent Federal matching rate for general administrative costs.

The IOM has recommended 100 percent Federal funding of the costs of the nursing home survey and certification activities of the States for 3 years. It has done so because of higher costs associated with its recommendations for implementing a resident-assessment system and a new resident-centered survey process both of which will require extensive training for all surveyors and nursing home staff. It should be noted that Federal funding for skilled professional personnel had been 100 percent prior to 1980 when Congress reduced the matching rate to 75 percent.

The President's budget for FY 1988 has proposed to eliminate special matching rates for administrative costs, including those for skilled professional medical personnel. Administrative costs would be matched at the regular 50 percent rate. The budget also proposes to reduce the matching rate for States with per recipient administrative costs that exceed a specified threshold. According to the Administration, this proposal would eliminate special subsidies which are no longer necessary and would give States with high administrative costs the incentive to achieve efficiencies.

III. ENFORCING COMPLIANCE WITH FEDERAL STANDARDS

A. Current Law and Policy

As noted above in section II, providers of nursing home services participate in the Medicare and Medicaid programs under provider agreements with HCFA (for Medicare), and with State Medicaid agencies (for Medicaid). In order to enter into a provider agreement, a SNF or ICF must first be certified by a State survey agency as complying with conditions of participation and standards for providing care. Facilities are surveyed periodically by State survey agencies to determine their compliance with these requirements.

The survey agency may certify a facility that fully meets requirements and standards for up to 12 months. Survey agencies may also certify a facility for participation if it is found to be deficient in one or more standards if the deficiencies, individually or in combination, do not jeopardize the health and safety of patients and if the facility submits an acceptable plan of correction for achieving compliance within a reasonable period of time. Medicare law also allows State survey agencies to furnish specialized consultative services to facilities which need to meet one or more conditions of participation. In addition, the Secretary is required to make public, in readily available form and place, the results of surveys of nursing homes.

Before the enactment of section 916 of the Omnibus Reconciliation Act of 1980, P.L. 96-449, if a State survey agency made a determination that a nursing home could not comply with requirements and standards for care, the only available sanction was to terminate the facility's provider agreement. Section 916 of P.L. 96-449 provided HCFA and State Medicaid agencies with an alternative intermediate sanction for deficient SNFs and ICFs. When a finding is made that a nursing home no longer substantially meets the law's requirements and standards of care, and deficiencies do not immediately jeopardize the health and safety of the facility's patients, the Secretary and/or State may, instead of terminating the facility's participation in the program, refuse to make payments on behalf of eligible individuals later admitted to the facility. However, if it is determined that the deficiencies do immediately jeopardize the health and safety of the facility's patients, the Secretary or State must terminate the facility's participation in the program. If the decision is made to deny program payment instead of terminating a facility's participation, the facility must achieve substantial compliance with program requirements or be found to have made a good faith effort to correct its deficiencies by the end of the 11th month following the month when a decision is made to deny payment.

Final regulations implementing these provisions became effective August 4, 1986.

B. Major Recommendations of the IOM Report on Enforcing Compliance with Federal Standards

The IOM makes the following recommendations on enforcing compliance with Federal standards for nursing homes participating in Medicare and/or Medicaid:

1. HCFA should revise its guidelines for the post-survey process. Revisions should include: 1) specifying that survey agency personnel not be used as consultants to providers with compliance problems; 2) specifying how to evaluate plans of correction and what constitutes an acceptable plan of correction; 3) specifying the circumstances under which onsite follow-up visits may be waived; 4) specifying circumstances under which formal enforcement action should be initiated, and how actions should be taken; and 5) requiring that States have formal enforcement procedures and mechanisms.

2. Medicaid authority should be amended to authorize a specified set of intermediate sanctions for use by States and by the Federal Government in enforcing compliance with nursing home conditions of participation and standards. The sanctions should include: a) ban on admissions; b) civil fines; c) receivership; and d) emergency authority to close facilities and transfer residents.

3. Medicaid statute should be amended to provide authority to impose sanctions on chronic or repeat violators of certification regulations. HCFA should develop detailed procedures to be followed by the States to deal with such facilities. Procedures should include, but not be limited to: a) the authority to impose more severe sanctions; b) a requirement to consider a

provider's previous record before certifying or recertifying; and c) the responsibility to obtain satisfactory assurances prior to recertifying, that the deficiencies that led to a termination will not recur.

4. The Medicaid statute should be amended to allow States to implement sanctions, particularly decertification, prior to hearings and appeals. Appeals initiated for the purpose of delaying correction of deficiencies should be discouraged by making it clear that serious violations do not merit stays, that sanctions will be based on the deficiency in performance found at the time of the survey and not on later events, and that reimbursement for legal and other costs of unsuccessful appeals will be denied.

5. HCFA should strengthen State enforcement capabilities by: a) requiring States to commit adequate resources to enforcement activities, including legal and other enforcement-related staff; b) requiring survey and certification survey agency staffs to include enforcement-related specialists, such as lawyers, auditors, and investigators, to work as part of special survey teams for problem situations and to help support enforcement decision-making; c) including more training in investigatory techniques, witness preparation, and the legal system in the basic surveyor training course; and d) providing Federal training support for State survey agency and welfare agency attorneys in nursing home enforcement matters.

6. HCFA should require States to make public all nursing home inspection and cost reports. These documents should be required to be readily accessible at nominal cost to consumers and consumer advocates, including State and local ombudsmen.

C. Discussion of Selected Issues Arising from IOM Report Recommendations on Enforcing Compliance with Federal Standards

1. Intermediate Sanctions for Providers Out of Compliance with Conditions of Participation and Standards of Care

In 1986, HCFA implemented intermediate sanction regulations that allow HCFA or State Medicaid agencies to suspend Medicare or Medicaid payments for new admissions to facilities with deficiences that do not pose immediate threats to the residents' health and safety but are serious enough to require more emphasis than just a plan of correction. IOM argues that stronger intermediate sanctions are needed and that they should be uniform across the States. IOM specifically recommends that sanctions include: 1) a suspension of new admissions for all residents and not just Medicare and Medicaid admissions; 2) civil fines; 3) receivership, which would prevent an owner or a administrator from continuing to operate a seriously deficient facility but would not force a facility to close and relocate residents; and 4) emergency authority to close facilities and transfer residents.

IOM points out that many States already use various intermediate sanctions, including the ones mentioned above, under their State licensing laws. Their availability and use vary widely by State. In addition, States indicate, according to IOM surveys, varying levels of satisfaction with the effectiveness of their sanctions.

IOM argues that Federal statutory authority for additional intermediate sanctions is necessary if States are to conduct effective and uniform enforcement programs. HCFA and certain representatives of the nursing home industry maintain, on the other hand, that States should be given the flexibility to determine for themselves which sanctions they should apply and which would yield the greatest benefits for the costs involved. Some have suggested a Federal mandate for additional intermediate sanctions only for those facilities with repeat violations.

2. Enforcement Resources

IOM found that the use of sanctions in a State is associated with, among other things, higher State appropriations for the survey agency, special enforcement training for surveyors, and survey procedures that required greater numbers of facility visits a year. IOM recommends increasing funding for Federal and State enforcement activities.

IOM also recommends that HCFA have its own financial and legal resources for enforcement. IOM's report indicates that special funds are not set aside at the Federal level for regional legal staff or legal actions pertaining to the sanctioning of nursing homes. In addition, regional offices have not allowed States to hire lawyers or other enforcement personnel or to pursue hearings and appeals with certification funds. Survey agency staffs rarely include specialists trained in investigation and enforcement nor are surveyors trained in building cases against deficient nursing homes.

While forthcoming HCFA regulations on the IOM report may address certain of these concerns, the President's budget does not propose additional funding for these activities and proposes certain decreases in State matching rates for survey and certification administrative expenses.

IV. AMENDMENTS TO THE OMBUDSMAN PROGRAM OF THE OLDER AMERICAN ACT

A. Current Law and Policy

Authorized under the Older Americans Act, the long-term care ombudsman program is charged with investigating and resolving complaints of residents of long-term care facilities relating to their health, safety, welfare, and rights. It also monitors Federal, State, and local laws and regulations affecting facilities. Ombudsmen are required to exercise oversight on SNFs, ICFs, as well as board and care homes, and other adult care homes.

The Older Americans Act authority for the ombudsman program requires each State agency on aging to establish and operate, either directly or by contract, the long-term care ombudsman program. The law requires that there be a full-time ombudsman at the State level. The State agency is required to assure appropriate access to facilities and patient records by the ombudsman and to establish a state-wide reporting system to collect and analyze data on complaints and conditions in facilities. A minimum expenditure of funds is required by States: 1 percent of the State allotment for title III supportive services under the Older Americans Act, or $20,000, whichever is greater. States can meet this requirement if, in any year, they spend an equal amount for the program from State or local sources.

A total of $18.5 million was used to support the ombudsman program (including funds from title III and other Federal and non-Federal sources). Of the total, $10.2 million was from the supportive services allotment under title III, representing 3.8 percent of the FY 1985 allotment.

Nationwide there are almost 9,000 persons staffing the ombudsman program; the majority, 87 percent, are volunteers. In addition to the program operated at the State level, there were 732 local, sub-State programs. Almost 34,000 complaints were received by the ombudsman program. Data from selected States showed that the most frequently reported complaints related to inadequate hygiene care; physical abuse; personal items lost, stolen or used by others; and understaffing.

B. Major Recommendations of the IOM Report on the Ombudsman Program

The IOM Report makes the following recommendations on the Ombudsman Program:

1. The Older Americans Act should be amended to:

a) establish the ombudsman program under a separate title in the Act;

b) increase funds for State programs by authorizing Federal-State matching formula grants for State ombudsman programs. The formula should provide each State with a minimum annual budget in the range of $100,000 (1985 dollars) plus an additional amount based on the number of elderly residents in the State. The Federal-State matching ratio should be two-thirds Federal and one-third State funds;

c) establish a statutory National Advisory Council composed of State ombudsmen, State and local aging agencies, provider and consumer representatives, State regulators, health care professionals (physicians, nurses, administrators, social workers), and members of the general public to advise on administration, training, program priorities, development, research, and evaluation;

d) authorize State-certified sub-State and local ombudsmen, including trained, unpaid volunteers, access to nursing homes and, with the permission of the resident, to a resident's medical and social records;

e) authorize public legal representation for ombudsman programs; and

f) exempt the ombudsman programs, including sub-State ombudsmen who are supported by funds from the State ombudsman program, from the antilobbying provisions of an Office of Management and Budget Circular.

2. The Secretary of Health and Human Services (HHS) should direct the Administration on Aging (AoA) to take steps to provide effective national leadership for the Ombudsman Program. At a minimum, the Commissioner of AoA should designate a senior full-time professional and some supporting staff to assume responsibility for administering the program. Priority should be given to establishing a national resource center for the program that would develop, in consultation with State programs, an information clearinghouse, training and other materials to assist States and guidance to States on data collection and analysis. The center should advise on establishing program priorities, and sponsor research and evaluation studies.

3. HCFA should require State long-term care regulatory agencies to develop written agreements with State ombudsman programs covering information-sharing, training, and case referral.

C. Discussion of Selected Issues Arising from IOM Report Recommendations on the Ombudsman Program

Bills have been introduced in the 100th Congress to revise the ombudsman program in light of the IOM recommendations. The Older Americans Act is being reviewed for reauthorization this year, and proposals to revise the ombudsman program are likely to be considered in the context of the reauthorization legislation.

V. QUALITY OF HOME HEALTH CARE UNDER MEDICARE AND MEDICAID

A. Medicare's Home Health Care Benefit

Medicare is a nationwide health insurance program for the aged and certain disabled persons intended primarily to address acute medical care needs. Included among those services covered by Medicare are home health care services.

To qualify for home health care serivces, the Medicare beneficiary must be confined to his or her home under the care of a physician. In addition, the person must be in need of part-time or intermittent skilled nursing care, or physical or speech therapy. There is no statutory limit on the number of home health visits covered under Medicare, just so long as the beneficiary continues to need intermittent skilled nursing care or physical or speech therapy. Nor is the patient subject to any cost-sharing, e.g., deductibles or coinsurance, for covered home health services.

Once the beneficiary qualifies for Medicare's home health benefit, the program will pay for the following services:

--part-time or intermittent nursing care provided by, or under the supervision of, a registered professional nurse;

--physical, occupational, or speech therapy;

--medical social services provided under the direction of a physician;

--medical supplies and equipment (other than drugs and medicines);

--medical services provided by an intern or resident enrolled in a teaching program in a hospital affiliated or under contract with a home health agency;

--part-time or intermittent services provided by a home health aide, as permitted by regulations; and

--any of the preceding items and services which are provided on an outpatient basis under arrangement made by a home health agency at a hospital or skilled nursing facility, or at a rehabilitation center, and which involve the use of equipment which cannot readily be made available to the individual in his place of residence.

Services must be provided by a home health agency certified to participate under Medicare, according to a plan of treatment prescribed and reviewed by a physician. Under Medicare, a home health agency is defined as a public or private organization primarily engaged in providing skilled nursing and other therapeutic health services; has policies established by a group of professional personnel, including one or more physicians and one or more registered nurses; maintains clinical records on all patients; is licensed according to State laws; and meets such other conditions of participation and requirements as the Secretary may find necessary for the health and safety of patients and for the effective and efficient operation of the program.

Medicare's spending for home health care benefits is a small proportion of total program expenditures. In 1985, home health expenditures amounted to 3.5 percent of total program expenditures. However, it is one of the fastest growing components of the Medicare budget. Between 1974 and 1985, home health care expenditures under Medicare increased from $138 million to $2.27 billion. This represented a 29 percent average annual compound rate of growth.

Persons receiving home health services under the Medicare program used an average of 27 visits in 1984. The number of persons receiving services has increased from 390,000 in 1974 to an estimated 1.52 million in 1984. The user rate increased from 16 persons per 1,000 enrollees in 1974 to 50 persons per 1,000 in 1984. The number of home health visits increased from 8.1 million in 1974 to 40.3 million in 1984. The number of home health agencies participating in Medicare increased from 1,786 in 1974 to 5,932 in 1985.

B. Home Care Services Under Medicaid

The Medicaid program is a Federal-State matching program providing medical assistance for certain low-income persons. Each State administers its own program and, subject to Federal guidelines, determines eligibility and scope of benefits. In general, each State also determines the payment rate for services provided to Medicaid recipients. The Federal Government's share of medical expenses is tied to a formula based upon the per capita income of the State. As a minimum, the Federal Government will pay 50 percent of the costs of medical care; this amount ranges up to 78 percent in the lower per capita income States.

Medicaid law requires the States to cover under their programs the "categorically needy"--all persons receiving assistance under the Aid to Families with Dependent Children (AFDC) program and most persons receiving assistance under the Supplemental Security Income (SSI) program. States may also cover additional persons as categorically needy. These might include persons who would be eligible for cash assistance, except that they are residents in medical institutions, such as skilled nursing or intermediate care facilities.

In addition to the categorically needy, States may at their option cover the "medically needy," persons whose income and resources are large enough to cover daily living expenses, according to income levels set by the State, but not large enough to pay for medical care. If the income and resources of the "medically needy" individual are above a State-prescribed level, the individual must first incur a certain amount of medical expense which lowers the income to the medically needy levels (so-called "spenddown" requirement).

1. Home Care Under Medicaid

States vary greatly in the services they cover under their Medicaid programs. They are required to offer in their plans certain services and can include certain other optional services. States are required to cover home health services for all persons entitled to SNF services. These include Medicaid beneficiaries over 21 years of age who are categorically needy. In addition, a State must provide home health services to (1) categorically needy beneficiaries under 21, if such individuals are eligible to receive SNF services under a State's Medicaid plan, and (2) medically needy beneficiaries if SNF services are offered to that group. States may provide such services to other program beneficiaries. According to Federal regulations, eligibility for home health services can not depend on a recipient's need for or discharge from institutional care.

The Federal Medicaid statute does not define the term home health services. However, Medicaid regulations require States to include a minimum range of home health services in their Medicaid programs. These include nursing services, home health aide services, and medical supplies and equipment. At the State's option, home health services may also include physical and occupational therapy, speech pathology and audiology services. Regulations also specify that the services can only be provided at the recipient's place of residence and upon orders of a physician as part of a written plan of care that the physician reviews every 60 days.

Under Medicaid, home health services are provided by home health agencies or facilities licensed by the State to provide medical rehabilitation services. Although the law does not define the term home health agency, Medicaid regulations define it as a public or private agency or organization, or a subdivision of such an agency or organization, which is qualified to participate as a home health agency under the Medicare program.

In 1985, home health care accounted for 3.0 percent of total Medicaid spending and amounted to approximately $1.1 billion. An estimated 535,000 persons received these services. Similar to the Medicare program's experience, home health expenditures have increased rapidly--from $31 million in 1974 to the $1.1 billion level for 1985, a 38 percent average annual compound rate of growth.

2. Personal Care Services

In addition, to home health care services, 27 States covered personal care services as an optional Medicaid service in 1985. Medicaid regulations require that personal care services in a recipient's home be prescribed by a physician in accordance with a recipient's plan of treatment and provided by an individual who is qualified to provide the services, who is supervised by a registered nurse, and who is not a member of the recipient's family. Personal care services usually assist in such activities of daily living as bathing, eating, and dressing. Program guidelines indicate that the purpose of personal care is to accommodate long-term maintenance or supportive care, as opposed to the short-term, skilled care required for some acute illnesses.

3. Home and Community-Based Waiver Services

Prior to the enactment of the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, Federal matching payments were generally not available under Medicaid for non-medical home health care-type services rendered to program beneficiaries. P.L. 97-35 included an amendment to the Medicaid program which authorizes the Secretary of HHS to grant waivers of certain Medicaid requirements in order to permit States to offer a broad range of home and community-based services. These services can be provided to individuals who would otherwise require, and have paid for by Medicaid, the level of care provided in a hospital, SNF or ICF. Services which may be provided under the waiver (in addition to those currently authorized under Medicaid) include case management (commonly understood to be a system under which responsibility for locating, coordinating, and monitoring a group of services rests with a designated person or organization), homemaker/home health aide services, personal care services, adult day health care services, habilitation services, respite care, and other services. To have a waiver request approved, a State must provide satisfactory assurances to the Secretary as to the safeguards taken to protect the health and welfare of recipients of services, the cost of services under the waiver, and the recipients need for services. As of January 31, 1987, 44 States had 105 approved waiver programs in operation.

C. Medicare and Medicaid Certification Requirements for Home Health Care Agencies

In order to participate as a home health agency in the Medicare and Medicaid programs, an agency must meet a number of specific requirements, or conditions of participation, contained in law and regulations. The conditions of participation contained in regulations govern three broad areas: personnel requirements for those providing care; organizational administrative requirements for an agency; and requirements for specific categories of home health services. These requirements have been in effect since 1973.

Similar to the procedures used for nursing home care, HCFA makes a determination as to whether a facility meets the requirements for participation in the Medicare program based on the survey and certification recommendations of a State survey agency. The surveys assess the exent to which the agencies meet the conditions of participation. The State agency fowards its findings and recommendations to HCFA, which then makes a determination whether the home health agency is in compliance with the conditions of participation.

D. Selected Issues in Quality of Care Provided by Home Health Agencies Participating in Medicare and Medicaid

1. Adequacy of Survey Activities for Participating Home Health Care Agencies

With the rapidly increasing numbers of home health agencies participating in Medicare and increasing numbers of persons being served, observers have pointed to the need for assessing the adequacy of current conditions of participation (in effect since 1973) for assuring quality of care. In addition, observers have suggested that survey coverage of home health care agencies should be increased. Home health agencies, for example, are surveyed only every 2 years.

Legislation has been introduced (H.R. 1700) to include additional conditions of participation for home health agencies participating in Medicare and Medicaid. In addition, the President's FY 1988 Budget proposes additional funding: (1) for increasing coverage levels for home health agencies from 53 percent to 75 percent; (2) for placing home health agencies on an average 18-month survey cycle as opposed to the current 24-month survey cycle; and (3) for responding to a State need for additional resources for surveying and terminating substandard agencies.

2. Patient-Oriented Surveys of Home Health Care

The home health care survey process has involved primarily a review of various records maintained at the agency. Observers have suggested that surveyors need to observe patients in their homes, in order to assess adequately the quality care provided by agencies. Recently HCFA has developed instructions for States to conduct visits to homes of beneficiaries receiving home health services to determine, through an on-site verification, whether Medicare conditions of participation are met. HCFA's Health Standards and Quality Bureau is conducting an assessment of an instrument developed for home visits and expects to report on this assessment soon. H.R. 1700 would require the Secretary to use for home health agencies, surveys which include patient-oriented assessment techniques.

3. Home Health Aide Training

Concern has been expressed about the qualifications and training of homemaker-home health aides, who, together with other paraprofessional and nonprofessional workers, provide the bulk of day-to-day supportive services in the home. In 1986, an American Bar Association's (ABA) report, the Black Box of Home Care Quality, found these personnel to be largely untrained or undertrained. The report recommended that at a minimum, homemaker-home health aides and personal care attendants should be required to complete an established and approved course of instruction, provided through a recognized educational entity, and leading to certification or licensure of the individual.

The Omnibus Reconciliation Act of 1980, P.L. 96-499, included an amendment to Medicare's home health care benefit to require that home health aide services be provided by persons who have successfully completed a training program approved by the Secretary. Regulations have not yet been published by the Secretary to implement this provision. The ABA's report found that only 13 States include in their licensure law or regulations for home health agencies - specific training requirements that include both minimum hours and minimum curriculum requirements, or incorporate, by reference a specific community college level curriculum.

4. Intermediate Sanctions

Observers have noted that short of termination, HCFA has no intermediate sanctions to invoke in order to obtain compliance from deficient home health care agencies. The intermediate sanction discussed above that suspends payments for new Medicare and Medicaid patients, applies only to SNFs and ICFs. Suggestions have been made to apply IOM recommendations on intermediate sanctions to home health care agencies as well. These would include a ban on all new admissions, civil fines, etc.

Senator MITCHELL. May we have order, please? Good afternoon, ladies and gentlemen. On behalf of the Subcommittee on Health, I welcome you to the second in our series of hearings focusing on long-term care.

Today, we will examine recommendations and suggestions for ways in which the Federal Government may help to ensure high quality of care for the one and one-half million Americans who reside in nursing homes and the additional millions who depend on home care services.

While it is appropriate that we focus on the problem, it is also important to note that there are large numbers of very dedicated officials and individual employees of nursing homes who provide care for our disabled and frail elderly population.

I am pleased that nursing homes and home care agencies in Maine are consistently above average in quality of care. Unfortunately, there is a considerable body of evidence indicating that there are serious problems with quality of care for chronic illness in some areas of the country.

In 1985, Congress requested that the Institute of Medicine conduct a study of the quality of care in nursing homes that would provide a careful review of the issues and suggest appropriate action. The Institute study group not only reviewed existing studies but held public hearings and conducted field interviews in many States. Their report, received in April of 1986, documents a number of reliable studies that indicate an inadequate level of care in a significant number of nursing homes.

The recommendations of the Institute have been extensively reviewed and discussed over the past year. Most notable is the work of a coalition of industry representatives, organizations representing health care professionals and nursing home employees, and consumer advocates.

This group, led by the National Citizens Coalition for Nursing Home Reform, is to be commended for their long and difficult effort in reaching a concensus on most of the more difficult issues. They have extended the work of the Institute in a significant and useful way.

I would also like to note the outstanding work of my colleague, Senator Heinz, who has been a leader in bringing this problem to the attention of the Congress in the past in introducing legislation in this area in the last Congress.

Unfortunately, Senator Heinz is unable to be with us today, as he was called away on personal business related to the recent death of his father.

Building on these past efforts, I am pleased to announce that today I will, with Senator Bradley and Senator Pryor, introduce legislation that includes many of the suggestions of the Institute, the Coalition, and which builds on prior legislation in this area. The bill includes provisions that will ensure adequate professional staffing, training for nursing aides, mandates quality assessment and assurance activities in nursing homes, and sets standards for survey and certification procedures.

The bill also calls for the creation of a national commission on long-term care. This commission, with broad representation from consumer, industry, and health care workers, is essential to address remaining problems of ensuring access, providing a more sensible system of reimbursement, and providing an ongoing forum for monitoring quality of care in both nursing homes and in home care.

Until now, little attention has been paid at the Federal level to the quality of care that home health agencies provide. In the past, home health agencies were generally free of quality problems, in part because the field was comparatively small. According to the National Association for Home Care, since the enactment of Medicare in 1965, there have been less than a dozen convictions of home care providers for fraud. We must be assured that this good record continues.

Last week, I joined with Senator Bradley and others in introducing the Medicare Home Health Services Improvement Act of 1987, which includes a provision to assure quality of care in the delivery of home health services under Medicare.

I look forward to the testimony to be presented by the witnesses today on the quality of care provided to the nation's elderly in long-term care facilities. We must work together to assure that Medicare and Medicaid beneficiaries receiving nursing home and home health services receive the highest quality care available and are protected from substandard care that may jeopardize their health and well-being.

I am pleased that our first witness is Dr. Roper. As always, Doctor, we look forward to hearing from you. I apologize to you and all of the other witnesses and the persons present today for the delay in beginning the hearing.

As I am sure you know, a vote occurred shortly after 2:00, which I and other Senators had to participate in; but we are pleased to have you here now, and as always, we welcome your testimony.

STATEMENT OF WILLIAM L. ROPER, M.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Dr. ROPER. Thank you, sir. It is a pleasure for me to appear before you again. I was late last time, so I am proud to be on time today.

Senator MITCHELL. The problem is that we can begin without you, but we can't begin without me. [Laughter.]

So, it is not as bad when you are late.

Dr. ROPER. Thank you. I truly am pleased to appear before you and the committee to discuss the work that we have underway, not only to maintain, but improve, the quality of care in America's nursing homes. Secretary Bowen, I, and HCFA take very seriously the responsibility we have to ensure the care that the elderly, sick, and disabled receive in America's nursing homes is of good quality. There is general agreement that the quality of care in nursing homes has been improving.

To quote from the Institute of Medicine's report, the IOM committee found that the consumer advocates, providers, and State regulators with whom it discussed these matters believe that a larger proportion of the nursing homes today are safer and cleaner, and the quality of care on the average probably is better than was the case before 1974; but importantly, as the IOM noted, there is room for improvement, and we certainly agree with that.

Through a partnership with the States, the Federal Government has made many improvements in the quality of care in nursing homes. Last July, we implemented a new long-term care survey process which focuses the surveyors' efforts on resident care. Previously, a surveyor was not required to spend enough time talking to the residents and really assessing their conditions.

The new approach has drastically changed what is actually done; now, surveyors spend most of their time in direct observation of residents—their conditions, their care, their services, and treatments—as well as the general condition of the facility. In fact, to require an accurate assessment of resident care, they conduct an in-depth interview with about one-fifth of all the residents in a facility.

We have been working to improve this process further, and have been meeting with consumers, providers, and State agencies. We have a contract with Brown University to evaluate the process and make recommendations for further changes.

We will make additional improvements through the publication soon of new conditions of participation and survey and certification regulations for nursing homes.

We are also working to see if we can replicate this outcome-oriented survey process in other settings, such as home health agencies. We have entered into a contract to develop a survey instrument designed objectively to survey the quality of care provided by home health agencies.

We have strengthened our procedures to terminate facilities that no longer meet Federal requirements, particularly if they have conditions which pose an immediate and serious threat to the health and safety of residents; and we will take action to terminate payment to those facilities.

Last year, 73 nursing homes and 12 home health agencies were terminated from Medicare and Medicaid. Another 166 nursing homes and 415 home health agencies voluntarily withdrew from participation, and many of these did so to avoid being terminated.

We have increased our budget for Medicare and Medicaid long-term care surveys. Since 1985, we have increased our nursing home survey budget by 46 percent. All of these efforts have contributed to an improvement in the care received by nursing home residents and individuals receiving home health agency services, but more work needs to be done.

The regulation of nursing homes is complex and difficult, and it should not be surprising that different observers have different ideas about the best approach.

The Institute of Medicine stressed the need to make major revisions to nursing home requirements and to our monitoring and enforcement rules. As I said earlier, we are now developing detailed statutory, regulatory, and administrative changes. We are developing revised nursing home conditions of participation requirements which will include provisions on residents' rights, resident assessment, quality of care, and quality of life.

We plan to reduce the paperwork burden on facilities and to focus requirements on positive outcomes of care to be achieved and negative outcomes to be avoided. We are developing revised survey and certification rules which adopt a flexible survey cycle, depending on the performance of the provider. We will strengthen our rules prohibiting certification of facilities which year after year continue to have problems; and we will define the time frame a facility must wait to reenter the program after having been terminated.

We will make all these changes through the regulatory process, publishing a notice of proposed rulemaking with a public comment period that will allow for maximum public involvement. We expect to receive many comments from organized groups, States, nursing homes, and residents; and we will, in our final regulation, respond to those comments.

We believe this open process with involvement of all the parties is the best process through which to revise these regulations. We, therefore, believe that the Congress should await the outcome of our rulemaking before undertaking statutory changes.

Some of the improvements that we want to implement, though, cannot be accomplished without legislative changes. We are developing a series of legislative proposals which would combine the survey and certification and inspection of care systems. These are separate in some States.

We seek the authority to penalize States that fail to implement our survey procedures and to permit States to make final certification determinations under Medicare as they now do under Medicaid, except for public facilities.

We do not agree with a small number of the IOM recommendations, which we believe do not affect the quality of care provided or our enforcement capability. For example, we don't believe it is feasible to require facilities to hire only nurses' aides who have received a certificate of competency. Rather, we are seeking to propose that aides be trained before being allowed to provide direct care. Likewise, we don't agree that it is necessary to require facilities to hire a social worker for each 100 residents. Rather, we want to ensure that a facility meets the psychosocial needs of the residents, whatever is necessary.

We are firm in our enforcement of the requirement that, once admitted, residents cannot be discriminated against on the basis of source of payment; but we don't believe it is appropriate to regulate private business by dictating admission policies with respect to Medicaid admissions.

We are committed to careful and orderly changes in our regulation of nursing homes. We recognize that both defining and ensuring quality can be accomplished only through a cooperative spirit with you, the Congress, the Administration, the provider community, and consumers. Together, we think we can make the appropriate improvements in our quality assurance system. We are committed to that task.

I will be glad to answer any of your questions.

Senator **Mitchell**. Thank you very much, Dr. Roper. Before I proceed to questioning, I would like to recognize Senator Pryor and ask the Senator if he has an opening statement he wishes to make.

Senator **Pryor**. Senator Mitchell, Mr. Chairman, thank you. I do have an opening statement. I would like to just insert it in the record. We appreciate Dr. Roper and the other witnesses being here today. Mr. Chairman, I look forward to working with you in developing this legislation.

Senator MITCHELL. Thank you very much, Senator. We will now proceed to questioning. In accordance with the committee's rules, there will be five minutes per round, and the questioning will occur in the order that the Senators appeared at the hearing.

Dr. Roper, first I want to compliment you for moving HCFA forward on this issue. This is clearly a task that should be bipartisan and cooperative and, as in other areas, I am impressed with your sincerity and your diligence; and we look forward to working with you on developing legislation.

I have a series of questions here that I would like to begin.

Dr. ROPER. Yes, sir.

Senator MITCHELL. In your response to the IOM report, you do not mention any recommendation as to professional nurse staffing; and yet recent data from the National Center for Health Statistics suggests that patients in both skilled and intermediate care facilities are increasingly more impaired and frail. Do you feel that the present arrangement under which an intermediate care facility can have only a nursing aide on duty on some shifts is adequate, and what would your reaction be to a gradual phase-in of 24-hour coverage for intermediate care facilities by either registered professional or licensed practical nurses?

Dr. ROPER. It is an important point, Senator, and let me respond first generally and then more specifically, if you wish.

We believe that good quality nursing services should be required in nursing homes, be they skilled nursing facilities or intermediate care facilities.

In some instances, ICFs do not require 24-hour coverage. Since not every facility in the country requires that, we don't believe the appropriate way to go is to mandate such a level of coverage for all—however many thousand—facilities there are in the country; but rather, to focus, as we are on the outcomes. We felt it preferable to say that whatever it takes, whatever the patient mix is, whatever the level of services there are—good quality care is what is required.

And through the survey process, we can make sure that that is the case. Many facilities do require 24-hour coverage, but not all; and so, to say that every single one of them has to have 24-hour coverage would be overdoing it in some facilities.

Senator MITCHELL. How do you propose to see that those that do need them get them? How do you propose to discern the distinction you have made?

Dr. ROPER. Through the survey process, using the new instrument that we put in place a year ago—actually going into the facility, inspecting it, surveying the actual needs of the patients in that facility, and making a judgment as to what level of care they require, on a facility-by-facility basis.

Senator MITCHELL. That would require some prior adoption of standards, would it not? You have to have some standard of measurement against which you make these suggested judgments that you were just talking about. You don't just go out and say to a group of people—different people in different parts of the country—go look and that facility and you decide whether or not it needs certain types of coverage.

Dr. ROPER. Our surveyors do have and would continue to need to have guidelines, instructions, and so forth, to determine the mix of patients and what nursing oversight is required. There is no question about that; but that is different from what I understood you to be suggesting, and that is a uniform requirement of so many nurses per patient.

Senator MITCHELL. The same issue arises in connection with social work coverage, especially in large skilled care facilities. The demands for effective discharge planning and psychosocial care are complex. How can someone with no training in social work be expected to handle the complexities of arranging and coordinating the services that are necessary for safe and lasting discharge?

Dr. ROPER. The same answer; you are right. Many facilities do require the skills of social workers, but not every one does. What we are saying is that every nursing home in America has to take care of the social and psychosocial needs of all of their residents, whatever is required to satisfy that requirement. Some facilities need a lot of social workers; some need one; others, depending on their patient mix, don't need a social worker.

That is why we believe in focusing on outcomes of care as the appropriate way to go.

Senator MITCHELL. No one disagrees with that as a principle. The difficulty is, of course, that to the extent you rely on subjective judgment and do not have clear and clearly understood specific standards, the much greater complexity is required and the administration in the determination and the much greater likelihood of disparity in enforcement. The obvious purpose of simply stated and simply understood national standards is that they are easy to understand and easy to apply.

I guess if you can convince us that we can accomplish the same purpose in a more discerning and cost-efficient way, we would be very receptive to that.

Dr. ROPER. I would be pleased to try.

Senator MITCHELL. Yes. I will suspend for now and go to Senator Pryor.

Senator PRYOR. Dr. Roper, in your statement, you did testify you did not agree with a number of the Institute of Medicine's recommendations, including the requirement that all nurse's aides hired by facilities have a certificate of competency. The Mitchell legislation requires 100 hours of training for nurse's aides before allowing them to provide direct care. Now, do you support Senator Mitchell's section of this legislation as to the 100 hours?

Dr. ROPER. We have suggested 80 hours as the figure.

Senator PRYOR. Now, why did you do that? [Laughter.]

Dr. ROPER. Our 80 hours, he wrote down as 100 hours!

Senator PRYOR. Now, let me ask you: If you were a nursing home patient, Dr. Roper, would you rather someone administering to you had 80 hours or 100 hours? I think we could adopt the Golden Rule here.

Dr. ROPER. I think the quality of the hours is what is important, Senator. I will make the general point again. What we obviously believe—and I hope it is obvious—is that nursing aides and other health professionals have to be trained. The Institute of Medicine suggested requiring that people achieve a certificate. What we are suggesting in our draft regulations is that, before people can give hands-on care to the residents of nursing homes, they have to go through a training program.

Everybody is seeking the same result, which is fully trained individuals working in nursing homes. No doubt about that.

Senator PRYOR. We hope you will relook at that section.

Dr. ROPER. Yes, sir.

Senator PRYOR. In your testimony, you discuss the changes the Department is considering with respect to the survey and certification process for long-term care facilities.

Now, I have some very serious concerns about the proposal that you bring to us this afternoon on page 6 of your testimony: to reduce the Federal matching rate for surveys from 75 percent to 50 percent. In other words, you are going to a 50/50 match between the States and the Federal Government, particularly when we are now asking the States out there for stepped-up efforts and when there are increased costs in carrying out the survey programs.

So, I want to know how you can justify this reduction in the Federal share.

Dr. ROPER. The original intent of the enhanced matching rates was to give the States a boost by covering start-up costs to bring their inspection programs along, and the various other things that were provided for in enhanced matching rates. Now that those functions are operating well, we believe that the same matching rate ought to apply across-the-board in the Medicaid program.

The States—at least many of them—are in difficult fiscal straits; but clearly, Senator, as you know from the vote you have just taken, the Federal Government is in difficult fiscal straits, and this is a step we believe is prudent. We believe that we share this responsibility with the States.

Senator PRYOR. I have made two references, by the way, George, to this being the Mitchell bill. I believe it is the Mitchell-Pryor-Bradley bill.

Senator MITCHELL. Yes.

Senator PRYOR. And maybe Durenberger bill. I am not certain. [Laughter.]

Senator MITCHELL. We want to get it passed. So, we are hoping to make it the Durenberger-Pryor-Bradley-Mitchell bill to get it passed. [Laughter.]

Senator PRYOR. Of course, it could be the Pryor-Mitchell-Bradley-Durenberger bill. [Laughter.]

Dr. ROPER. If you will pardon me, we will publish regulations that will not require a bill at all.

Senator PRYOR. I am not sure you can implement what you have right now, Dr. Roper, but I hope you will try.

Dr. ROPER. We are working on it.

Senator PRYOR. In March, the U.S. District Court in Denver, Dr. Roper, as you know, ruled a procedure used in implementing the so-called Patient Care and Services Survey, was invalid. Now, I think that was the ruling of the court there, the Federal court. And I know that the Department intends to issue additional regulations on this subject and very soon—we hear next month. Do you intend to fully comply with the court's ruling? Do you have a general idea of when we might expect to see these changes implemented?

Dr. Roper. Of course, we intend to comply fully with the court's order. The finding of the court was that we had not fully complied with certain procedural requirements in promulgating these regulations. They found—not that the regulations themselves were flawed—but that we erred on the process.

And so, next month we are going to publish a new notice of proposed rulemaking with a longer comment period, as required by the court; but the States are using the process right now to survey nursing homes. So, we are continuing to benefit from the action that we took last year.

Senator Pryor. I think my time is about to expire. Thank you, Mr. Chairman.

Senator Mitchell. Thank you, Senator Pryor. Senator Durenberger.

Senator Durenberger. Bill, just one question. Looking over the communications and the response that I have gotten from my constituents in Minnesota, the same question that they have is whether or not the financial impact of these proposals will result in corresponding reimbursements?

Can you address that issue briefly?

Dr. Roper. You mean if nursing homes are asked to do more, will they be paid more?

Senator Durenberger. Yes.

Dr. Roper. That is up to the State Medicaid programs, the State of Minnesota, of course, in your case. They are the ones that determine the levels of payment in the States.

Senator Durenberger. I happen to be the author of one of these mandate bills, too. We increase the mandates and the service requirements, and somebody else ends up paying the bill. Is that in effect what we are facing here?

Dr. Roper. I think, to be realistic, yes, sir. Before you came in the room I was talking to Senator Mitchell about the requirement for enhanced nursing services in all nursing homes in America. And I was making the point that we don't believe that it should be required in every single nursing home. What we prefer is the requirement that adequate nursing services be provided, because it will clearly cost more to have 24-hour RNs in every nursing home in America. I think you are on target.

Senator Durenberger. Thank you.

Senator Mitchell. Thank you, Senator Durenberger. Dr. Roper, do you believe that States should be permitted to inspect their own facilities? Wouldn't that present a conflict of interest?

Dr. Roper. I think they ought to be permitted to inspect all except State-owned facilities. That is a Federal responsibility.

Senator Mitchell. So, you do agree that State-owned facilities should not be inspected by States?

Dr. Roper. Let me make sure of what I said a minute ago.

Senator Mitchell. I think in your response to the IOM, you said the opposite of what you have just said; but we accept your most recent statement as the considered judgment of your agency. [Laughter.]

Dr. **Roper**. My answer, I have to correct, is that States could survey, but we would be the ones certifying a State-owned facility. We think that is a function that ought to be reserved for the Federal Government.

Senator **Mitchell**. You did better when you were on your own. [Laughter.]

Dr. **Roper**. You are right.

Senator **Mitchell**. I think you ought to rethink that one.

Dr. **Roper**. Yes, sir.

[A letter from William S. Roper follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

JUL 6 1987

Senator George J. Mitchell
United States Senate
Washington, D. C. 20510

Dear Senator Mitchell:

When I appeared before your Subcommittee on April 28 to testify on the quality of care in nursing homes, you asked me to consider the appropriate roles for State and Federal authorities in the survey and certification process of State operated facilities. Currently State officials have responsibility for conducting surveys of State facilities and for making final certification determinations for Medicaid participation.

In its report "Improving the Quality of Care in Nursing Homes," the Institute of Medicine (IOM) recommended that Medicaid survey and certification of State facilities be conducted by Federal regional officials in the Health Care Financing Administration. You suggested that this IOM recommendation would eliminate any potential conflict of interest in the current Medicaid survey and certification process of State operated facilities.

I agree that it is important to guard against conflicts of interest in the certification process and believe that this objective can be met without moving to a fully Federal process. Therefore, we are considering a legislative change that will place the authority for final certification of State facilities for Medicaid participation at the Federal level with HCFA. However, to do this in an efficient manner State officials will remain responsible for conducting the surveys. Their survey findings will be used by HCFA officials in making the final certification determination. It would be far more costly to implement a fully Federal survey process requiring an additional 600 Federal surveyors and stationing them in the States or requiring extensive travel.

We have comprehensive data from our ongoing reviews of State survey activities comparing the survey and certification findings of State and Federal surveyors in the same facilities. In an analysis of surveys conducted in fiscal years 1986 and 1987 the level of concurrence between State and Federal surveys was 97 percent for skilled nursing facilities, 94 percent intermediate care facilities for the retarded, and 95 percent for Home Health Agencies. By sharing this responsibility with the States, I believe we can have a cost effective and efficient survey program for State facilities that will ensure quality of care and minimize any conflict of interest that could arise under the current system.

I would be happy to discuss this with you further.

Sincerely,

Bill

William L. Roper
Administrator

Senator **Mitchell**. Now, in some States, nearly all Medicaid nursing homes are skilled; in others, they are almost all intermediate. In view of that discrepancy, do you think the present definitions of skilled and intermediate care are adequate for either staffing or payment?

Dr. **Roper**. I think they are vague, and that is one of the things that we want to change in these regulations that we are putting forward. Some would say that, in view of the differences across the States that you mentioned, what is required is eliminating the distinction entirely.

We don't think that is appropriate. Rather, we think that clearer definitions are in order, and that is what we seek to provide in our regulations because there are in nursing homes in every State differing levels of care necessary for different residents.

Senator **Mitchell**. In February, I held a series of public meetings in Maine on the issue of long-term care; and one of the recurring problems that was raised in my State, and I believe it exists in more than one State, is the admitting of private pay patients in preference to Medicaid patients.

Dr. **Roper**. Yes, sir.

Senator **Mitchell**. Now, do you agree that that is an issue in many areas of the country? And if so, how do you propose to deal with this?

Dr. **Roper**. There are two issues—well, there are a multitude of issues—but two at least. One is the decision that is made by a facility at the time a patient is initially admitted, and the second is what happens once a person is admitted if his or her payment status changes.

Clearly, it is a violation of law and regulation to change the way services are rendered to a patient if he or she exhausts private payment and becomes Medicaid eligible.

Senator **Mitchell**. That is after admission?

Dr. **Roper**. After admission.

Senator **Mitchell**. That wasn't what I was talking about.

Dr. **Roper**. I know. I was just going to add that, last summer, I sent a letter to every State health officer in the country making clear that they ought to enforce that provision.

We don't think it is appropriate to impose barriers or to regulate the private businesses—which, after all, is what nursing homes are—and say that they have to take every patient who comes to them regardless of their ability to pay.

Clearly, it is within the rights of the operator of the nursing home to decide what services they are going to render and to whom. So, we are not in favor of requiring nursing homes to serve everybody on a first-come first-served, as it is sometimes called.

Senator **Mitchell**. Do you agree there is a problem? And you are saying that you don't think there is anything we can do about it? Or are you suggesting that it isn't a problem that that occurs on a regular basis?

Dr. **Roper**. The fact that nursing homes are able to decide what level of care to give is not a problem. If somebody is kicked out of a nursing home once there, or is discriminated against——

Senator **Mitchell**. No, no. You keep coming back to that. That is not what I am talking about. I am talking about the initial choice.

Dr. **Roper**. We don't view that as a problem.

Senator **Mitchell**. You don't view that as a problem?

Dr. **Roper**. No, sir.

Senator **Mitchell**. Senator Chafee.

Senator **Chafee**. Thank you, Mr. Chairman. Dr. Roper, in the 1985 Reconciliation Act, which has the unfortunate acronym of COBRA, we included within that a provision to allow institutions that were cited as not meeting ICFMR standards to come up with a proposal that would include some temporary fixes, while they were moving individuals into community placements. Do you remember that?

Dr. **Roper**. Yes, sir. I do.

Senator **Chafee**. That is the so-called "phase down" provision.

Dr. **Roper**. Yes, sir.

Senator **Chafee**. Now, I have a question for you. That was signed into law in April of 1986, which is a year ago. And no regulations have been published; and, therefore, no State is able to use the provision. So, we have the problem of the States being caught in this "Catch 22" situation of having spent money to upgrade—which are nonlifesaving activities—and thus depriving them of money that they would prefer to spend on out placement. What is the matter here?

Dr. **Roper**. We are publishing the final regulation shortly. The final regulation is being reviewed in the Department. We have completed our work on it and will be publishing it very shortly.

Senator **Chafee**. What does "very shortly" mean?

Dr. **Roper**. I don't have a firm fix for you, sir. I will be glad to provide it for you for the record. It is an important provision of COBRA, and we aim to implement it very quickly.

[The prepared information follows:]

The regulation is undergoing review within the Administration. We are making every effort to expedite that process.

Senator **Chafee**. I am disappointed that it has taken so long because I don't think it was all that difficult. Have you had problems with the provision?

Dr. **Roper**. No, sir.

Senator **Chafee**. Or is it just mechanical problems?

Dr. **Roper**. We currently have 140 regulations in process in HCFA at the moment. It is just that you gave us a lot of work in COBRA and OBRA.

Senator **Chafee**. Let me ask you this. When you decide in your Department on it, is there a long delay period that you have to go out for comment and then publish in the Federal Register and on and on? Let's say you came out with the provisions in three weeks. You are ready. When do they go into effect?

Dr. **Roper**. This is a final regulation that will be published. We have already gone through the comment period, Senator; and it will be in effect on the day it is published.

Senator **Chafee**. All right. Well, I know where to find you, anyway——

[Laughter.]

Dr. **Roper**. Thank you, sir.

Senator CHAFEE. We will look forward to that. Why don't you just give me an estimate?

Dr. ROPER. I will be glad to do that.

Senator CHAFEE. Go ahead. [Laughter.]

Dr. ROPER. A couple of weeks.

Senator CHAFEE. A couple of weeks?

Dr. ROPER. Yes, sir. All right.

Senator CHAFEE. Scout's honor? [Laughter.]

Dr. ROPER. I will do my darnedest, Senator.

Senator CHAFEE. All right, thank you. Thank you, Mr. Chairman.

Senator MITCHELL. Senator Pryor?

Senator PRYOR. In your former life, Dr. Roper, were you a pediatrician?

Dr. ROPER. I still am a pediatrician. [Laughter.]

Senator PRYOR. All right. Did you not tell me or the committee one other time that you had worked in a nursing home or had been involved in some way in a professional capacity in a nursing home?

Dr. ROPER. I think I had mentioned I had been a local and State health official involved in the regulation of these programs, I also have had a family member in a nursing home. Maybe that is what reference you remember.

Senator PRYOR. All right. I don't know this, and I am not baiting you and I am not leading off the path anywhere, but about how many employees does HCFA have?

Dr. ROPER. Roughly 3,900.

Senator PRYOR. All right. What would be wrong with mandating, before going to work for HCFA, that each potential employee or each given employee at some time during the next year to spend two weeks working in a nursing home and seeing and experiencing what really goes on? You are dealing with regulations; you are dealing with statistics and facts and figures. And somehow or another, I propose that this might help humanize——

Dr. ROPER. I understand your point, and I think it is a serious one. Last summer, I went with our inspectors and spent a day inspecting a nursing home myself to get at the very point you are making; I thought that was a very valuable experience for me.

One of the things I learned is that nursing homes are not fun places. That is not an attempt at humor. I think that nursing homes are a necessary part of our society, but it requires real vigilence on the part of the people who operate them and our inspectors, to make sure that the care that is given is appropriate.

Senator PRYOR. I think it is commendable that you spent a day; however, I also think it is worthy of consideration for people to also spend a night in a nursing home.

Dr. ROPER. Yes, sir.

Senator PRYOR. Because I think a day in a nursing home and a night in a nursing home are two different worlds. I am afraid this is true. So, please give some consideration to that. Maybe in the Durenberger-Mitchell-Bradley-Pryor bill, we will offer an amendment to require this. I don't know whether that would be involuntary servitude——

Dr. ROPER. Let me just add that not all 3,900 are involved in the regulation of nursing homes.

Senator PRYOR. Right, I understand that.

Dr. **Roper**. All right.

Senator **Pryor**. But you see the general thought I had.

Dr. **Roper**. Yes, sir.

Senator **Pryor**. That is all I have, Mr. Chairman.

Senator **Chafee**. Mr. Chairman, I have another brief question, if I might?

Senator **Mitchell**. Senator Chafee.

Senator **Chafee**. Dr. Roper, getting back to the phase down provision I was referring to before, it is has been my understanding that HCFA has stated that this provision should not be available unless the State was cited for a deficiency after the regulations are published.

Now, that wasn't the intention when we enacted that amendment. I was the sponsor of that amendment, so I am fairly familiar with it; and it was our understanding that the provision be effective upon enactment. Do you have any information on that? And if you don't, could you provide it for the record?

Dr. **Roper**. I will be glad to provide it, Senator.

Senator **Chafee**. But I would rather you have it yourself.

Dr. **Roper**. What I am told is that our position—and this is with the support of the General Counsel—is that it will be effective upon enactment. That is currently under review in the Department, as I mentioned to you, and I will be glad to carry your point back in our discussions.

As I said, we are in the last stages of clearing the regulation.

Senator **Chafee**. Just so you can have it from the person who sponsored the amendment, it was our intention to be effective upon enactment, and not some delay period.

Dr. **Roper**. Yes, sir.

Senator **Chafee**. Thank you, and thank you, Mr. Chairman.

[The prepared information follows:]

The phase down provision in the COBRA legislation contained three important references to timeframes for implementation. First, the legislation is "effective upon enactment," yet is also required the Secretary to publish a Notice of Proposed Rulemaking within 60 days, which we interpreted to mean that the Congress clearly wanted the public to participate in the process of implementing the law. Finally, Section 1919 (f) explicitly states that "the provisions of this section shall apply only to plans of correction and reduction approved by the Secretary within 3 years after the effective date of final regulations implementing this section."

One option would be to accept no plan until the regulation is final, but allow, the regulation to apply to all surveys performed on or after the enactment of COBRA (April 7, 1986).

The final details of the regulations are being reviewed by the Department.

Senator **Mitchell**. Dr. Roper, I want to get back to the last question I asked you regarding the preference given to private pay patients over Medicaid patients. We have prided ourselves in our country on not having a dual system of health care, not having a class State system.

While some would argue that we do not attain that objective in real life, nonetheless we strive for it. I must say I am a little bit troubled by the fact that you don't think that is any problem at all. There is a shortage of nursing home beds, and you have a waiting list; and the first 49 people who sign up are Medicaid patients, and the 50th is not; but number 50 can be selected over the first 49 by virtue of their status as a private pay patient.

And because a person is a Medicaid patient—and that is by definition, therefore, a poor person—that they are to be denied access. I can see the perspective of the nursing home operator, and it is a difficult issue. What troubles me is not that you don't have a ready solution, but you don't think it is a problem at all.

If your response is that you don't think it is a problem and you think that the nursing home operator ought to have the right to take in who they want, do you see the difficulty in that?

Dr. ROPER. I do see the difficulty, Senator. Let me elaborate on my response. My response would be that States ought to have enough nursing homes to provide quality services to patients, whatever their payment status, including patients who are Medicaid recipients.

Senator MITCHELL. But the reality is that they do not.

Dr. ROPER. That is a problem then. If that is the question, let me change my earlier "no" to a "yes." That is a problem; but to go further, there are tiers of care—levels of care. We don't have a two-tiered health care system; we have a multi-tiered health care system. And I am not advocating that we ought to have everybody at one level.

What I am saying is that we ought to make sure that the bottom tier gets good quality health care services, that they have access to whatever they need, be it nursing home services or doctor services or hospital services.

If somebody wants to have "Hyatt or Waldorf Astoria" nursing home services, I don't think it is in the public interest to require that they be brought down so that everybody is at the same level. What we in the public organizations ought to be focusing on is the adequacy of care at the bottom of the tiers.

Senator MITCHELL. I must say, with all due respect, that I think your answer is somewhat distorting the question. No one has suggested—and I did not intend to suggest—that we reduce everyone to the lowest common denominator.

But the question is the existence of the service at all for some people.

Dr. ROPER. Clearly, the service must exist.

Senator MITCHELL. But the reality is that it doesn't. There is a shortage, and you do have this case where a choice must be made, and the choice is now being made on a regular basis, based solely upon that factor—private pay versus Medicaid. And while it is a difficult issue, and while obviously the nursing home operator has rights and those rights must be protected, I am troubled by the fact that I guess you don't share my perception that it is a problem; and I am trying to get your participation in devising ways we can deal with this.

Dr. ROPER. Sure. I don't believe I am distorting things in my Hyatt or Waldorf Astoria point. If the solution is to say that an institution must accept anybody who comes forward with Medicaid payment, then over a relatively short period of time, the nursing home industry is going to gear all of their services to that level of payment.

Senator MITCHELL. Now, I wasn't suggesting a solution. What I was asking for was a recognition that a problem exists and inviting you to participate with us in trying to fashion a reasonable response to that.

Dr. **Roper**. I welcome your invitation; and if there are Medicaid recipients who do not have access to care, we have a problem. I agree.

Senator **Mitchell**. All right, then. Thank you very much. Do either Senator Durenberger or Senator Pryor have any further questions?

Senator **Pryor**. No, Mr. Chairman.

Senator **Durenberger**. No, Mr. Chairman.

Senator **Mitchell**. All right. Thank you very much, Dr. Roper. As always, you have presented us with an informative view.

Dr. **Roper**. Thank you.

[The prepared written statement of Dr. Roper follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF

WILLIAM L. ROPER, M.D.

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SENATE FINANCE SUBCOMMITTEE ON HEALTH

APRIL 28, 1987

SUMMARY STATEMENT OF WILLIAM L. ROPER, M.D.
ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION
APRIL 28, 1987

I am pleased to have this opportunity to discuss our accomplishments and our plans to ensure that nursing homes provide good quality care to Medicare and Medicaid beneficiaries. There is no more important consideration to Secretary Bowen and the Health Care Financing Administration than assuring that the elderly, sick, and disabled receive good health care. There is agreement that the quality of care in nursing homes has been improving. But as the IoM noted, there is room for improvement, and we agree.

Last July we implemented the new long term care survey process. This new process focuses a surveyor's efforts on resident care. Now surveyors spend most of their time in direct observation of residents and conducting in depth interviews with them. We are working to see if we can replicate the outcome-oriented survey process in other settings such as home health agencies. We have also strengthened our procedures to terminate facilities that no longer meet federal requirements. We have increased our survey budget for nursing homes since fiscal year 1985 by 46 percent.

The IOM stressed the need to make major revisions to the nursing home requirements and to our monitoring and enforcement rules. We are now developing detailed statutory, regulatory and administrative proposals. We are developing revised conditions of participation which will include provisions on residents rights, resident assessment, quality of care and quality of life; reduce the paperwork burden on facilities significantly; and focus requirements on positive outcomes of care to be achieved and negative outcomes to be avoided. We are also proposing to adopt a flexible survey cycle depending on the performance of the provider; strengthen our rules prohibiting certification of facilities year after year which go in and out of compliance continuously; and define the time frames a facility must wait to reenter the program after having been terminated from participation. We will make most of these changes through the regulatory process with a public comment period that will allow for the maximum public involvement. We expect to receive many comments, and in our final regulation we will respond to the public comments.

We did not agree with a small number of IOM recommendations which, we believe, do not affect the quality of care provided or our enforcement capability. However, we are committed to careful and orderly changes in our regulations. We recognize that both defining and assuring quality can be accomplished only through the cooperative spirit among Congress, the Administration, the provider community and consumers.

I AM PLEASED TO HAVE THIS OPPORTUNITY TO DISCUSS OUR ACCOMPLISHMENTS AND OUR PLANS FOR FUTURE ACTION TO ENSURE THAT NURSING HOMES PROVIDE GOOD QUALITY CARE TO MEDICARE AND MEDICAID BENEFICIARIES. THERE IS NO MORE IMPORTANT CONSIDERATION TO SECRETARY BOWEN AND THE HEALTH CARE FINANCING ADMINISTRATION THAN ASSURING THAT THE ELDERLY, SICK, AND DISABLED RECEIVE GOOD HEALTH CARE.

THERE IS AGREEMENT THAT THE QUALITY OF CARE IN NURSING HOMES HAS BEEN IMPROVING. TO QUOTE THE INSTITUTE OF MEDICINE IN ITS RECENT STUDY OF QUALITY OF CARE IN NURSING HOMES, "THE (IOM) COMMITTEE FOUND THAT THE CONSUMER ADVOCATES, PROVIDERS, AND STATE REGULATORS WITH WHOM IT DISCUSSED THESE MATTERS BELIEVE THAT A LARGER PROPORTION OF THE NURSING HOMES TODAY ARE SAFER AND CLEANER, AND THE QUALITY OF CARE, ON THE AVERAGE, PROBABLY IS BETTER THAN WAS THE CASE PRIOR TO 1974." BUT, AS THE IOM NOTED, THERE IS ROOM FOR IMPROVEMENT, AND WE AGREE.

THROUGH A PARTNERSHIP BETWEEN THE STATES AND FEDERAL GOVERNMENT WE HAVE MADE MANY IMPROVEMENTS IN THE QUALITY OF CARE IN NURSING HOMES.

LAST JULY WE IMPLEMENTED THE NEW LONG TERM CARE SURVEY PROCESS. THIS NEW PROCESS FOCUSES A SURVEYOR'S EFFORTS ON RESIDENT CARE. PREVIOUSLY, A SURVEYOR WAS NOT REQUIRED TO SPEND ENOUGH TIME TALKING TO THE RESIDENTS AND ASSESSING THEIR CONDITION. THE NEW

APPROACH HAS DRASTICALLY CHANGED THAT. NOW SURVEYORS SPEND MOST OF THEIR TIME IN DIRECT OBSERVATION OF RESIDENTS--THEIR CONDITION, THEIR CARE, SERVICES, AND TREATMENTS, AS WELL AS THE GENERAL CONDITION OF THE FACILITY. TO ACQUIRE AN ACCURATE ASSESSMENT OF RESIDENT CARE, THEY CONDUCT IN-DEPTH INTERVIEWS WITH ABOUT 20 PERCENT OF THE RESIDENTS.

WE HAVE BEEN WORKING TO IMPROVE THIS SURVEY PROCESS THROUGH MEETINGS WITH CONSUMERS, PROVIDERS AND STATE SURVEY AGENCIES. WE ALSO HAVE A MAJOR CONTRACT WITH BROWN UNIVERSITY TO EVALUATE THIS NEW PROCESS AND MAKE RECOMMENDATIONS FOR ANY APPROPRIATE CHANGES. WE WILL MAKE FURTHER IMPROVEMENTS THROUGH THE PUBLICATION OF NEW CONDITIONS OF PARTICIPATION AND SURVEY AND CERTIFICATION REGULATIONS.

WE ARE WORKING TO SEE IF WE CAN REPLICATE THE OUTCOME-ORIENTED SURVEY PROCESS IN OTHER SETTINGS SUCH AS HOME HEALTH AGENCIES. WE HAVE ALREADY ENTERED INTO A CONTRACT WITH ABT ASSOCIATES TO DEVELOP A SURVEY INSTRUMENT DESIGNED TO OBJECTIVELY SURVEY THE QUALITY OF CARE PROVIDED BY HOME HEALTH AGENCIES.

WE HAVE STRENGTHENED OUR PROCEDURES TO TERMINATE FACILITIES THAT NO LONGER MEET FEDERAL REQUIREMENTS, PARTICULARLY IF THE CONDITION POSES AN IMMEDIATE AND SERIOUS THREAT TO THE HEALTH AND SAFETY OF RESIDENTS.

IN FISCAL YEAR 1986, 73 NURSING HOMES AND 12 HOME HEALTH AGENCIES WERE TERMINATED FROM MEDICARE AND MEDICAID. ANOTHER 166 NURSING HOME AND 415 HOME HEALTH AGENCIES VOLUNTARILY WITHDREW FROM PARTICIPATING IN THE PROGRAMS, MANY OF WHICH DID SO TO AVOID BEING TERMINATED.

WE HAVE INCREASED OUR BUDGET FOR MEDICARE AND MEDICAID LONG TERM CARE SURVEYS. IN FISCAL YEAR 1985, $89 MILLION WAS SPENT ON SURVEY AND CERTIFICATION, WITH THE STATES ADDING $13 MILLION. $57.8 MILLION OF THE FEDERAL DOLLARS WENT FOR SURVEY AND CERTIFICATION OF NURSING HOMES. FOR FISCAL YEAR 1988, THE PRESIDENT HAS ASKED FOR $123 MILLION WITH THE STATES EXPECTED TO SPEND AN ADDITIONAL $18 MILLION. $84.3 MILLION OF THE FEDERAL DOLLARS WILL BE DEVOTED SPECIFICALLY TO NURSING HOMES. THIS MEANS THAT SINCE FISCAL YEAR 1985, WE HAVE INCREASED OUR NURSING HOME SURVEY BUDGET BY 46 PERCENT.

ALL OF THESE EFFORTS HAVE CONTRIBUTED TO AN IMPROVEMENT IN THE CARE RECEIVED BY NURSING HOME RESIDENTS AND INDIVIDUALS RECEIVING HOME HEALTH AGENCY SERVICES. HOWEVER, WE RECOGNIZE THAT ADDITIONAL WORK NEEDS TO BE DONE.

THE REGULATION OF NURSING HOMES IS COMPLEX AND DIFFICULT. IT SHOULD NOT BE SURPRISING THAT VARIOUS OBSERVERS OFTEN DISAGREE ON THE BEST APPROACH. THE IOM STRESSED THE NEED TO MAKE MAJOR REVISIONS TO THE NURSING HOME REQUIREMENTS AND TO OUR MONITORING

AND ENFORCEMENT RULES. WE ARE NOW DEVELOPING DETAILED STATUTORY, REGULATORY AND ADMINISTRATIVE PROPOSALS.

WE ARE DEVELOPING REVISED NURSING HOME CONDITIONS OF PARTICIPATION REQUIREMENTS WHICH WILL INCLUDE PROVISIONS ON RESIDENTS' RIGHTS, RESIDENT ASSESSMENT, QUALITY OF CARE AND QUALITY OF LIFE. WE PLAN TO REDUCE THE PAPERWORK BURDEN ON FACILITIES SIGNIFICANTLY, AND TO FOCUS REQUIREMENTS ON POSITIVE OUTCOMES OF CARE TO BE ACHIEVED AND NEGATIVE OUTCOMES TO BE AVOIDED.

WE ARE DEVELOPING REVISED SURVEY AND CERTIFICATION RULES, WHICH ADOPT A FLEXIBLE SURVEY CYCLE DEPENDING ON THE PERFORMANCE OF THE PROVIDER; STRENGTHEN OUR RULES PROHIBITING CERTIFICATION OF FACILITIES YEAR AFTER YEAR WHICH GO IN AND OUT OF COMPLIANCE CONTINUOUSLY; AND DEFINE THE TIME FRAMES A FACILITY MUST WAIT TO REENTER THE PROGRAM AFTER HAVING BEEN TERMINATED FROM PARTICIPATION.

WE WILL MAKE THESE CHANGES THROUGH THE REGULATORY PROCESS, PUBLISHING A NOTICE OF PROPOSED RULEMAKING, WITH A PUBLIC COMMENT PERIOD THAT WILL ALLOW FOR THE MAXIMUM PUBLIC INVOLVEMENT. WE EXPECT TO RECEIVE MANY COMMENTS FROM ORGANIZED GROUPS, STATES, NURSING HOMES, AND RESIDENTS. AND IN OUR FINAL REGULATION WE WILL RESPOND TO THE PUBLIC COMMENTS. WE BELIEVE THAT THROUGH THIS PROCESS OF OPEN INVOLVEMENT WITH ALL PARTIES, WE WILL BE

ABLE TO PRODUCE A SET OF REVISED REGULATIONS THAT WILL MEET OUR GOAL OF FURTHER IMPROVING QUALITY OF CARE IN NURSING HOMES. WE THEREFORE BELIEVE THE CONGRESS SHOULD AWAIT THE OUTCOME OF OUR RULEMAKING BEFORE UNDERTAKING STATUTORY CHANGES.

SOME RECOMMENDATIONS CANNOT BE ACCOMPLISHED WITHOUT LEGISLATIVE CHANGES. WE ARE DEVELOPING A SERIES OF PROPOSALS, WHICH COMBINE THE SURVEY AND CERTIFICATION AND INSPECTION OF CARE SYSTEMS, WHICH IN MANY STATES ARE TWO SEPARATE ACTIVITIES THAT OFTEN CONFLICT WITH EACH OTHER; ESTABLISH THE AUTHORITY TO PENALIZE STATES THAT FAIL TO IMPLEMENT OUR SURVEY PROCEDURES; AND PERMIT STATES TO MAKE FINAL CERTIFICATION DETERMINATIONS UNDER MEDICARE AS THEY NOW DO UNDER MEDICAID, EXCEPT FOR PUBLIC FACILITIES, WHICH WE WOULD CERTIFY.

WE DID NOT AGREE WITH A SMALL NUMBER OF IOM RECOMMENDATIONS WHICH, WE BELIEVE, DO NOT AFFECT THE QUALITY OF CARE PROVIDED OR OUR ENFORCEMENT CAPABILITY. FOR EXAMPLE, WE DO NOT BELIEVE IT IS FEASIBLE TO REQUIRE FACILITIES TO HIRE ONLY NURSES AIDES WHO HAVE RECEIVED A CERTIFICATE OF COMPETENCY. RATHER, WE ARE CONSIDERING PROPOSING THAT AIDES BE TRAINED BEFORE BEING ALLOWED TO PROVIDE DIRECT CARE. LIKEWISE, WE DO NOT AGREE THAT IT IS NECESSARY TO REQUIRE THAT FACILITIES HIRE A SOCIAL WORKER FOR EACH 100 RESIDENTS. RATHER, WE WANT TO ENSURE THAT A FACILITY MEETS THE PSYCHOSOCIAL NEEDS OF THE RESIDENTS. WE ARE FIRM IN OUR ENFORCEMENT OF CURRENT REQUIREMENTS THAT, ONCE ADMITTED, RESIDENTS CANNOT BE DISCRIMINATED AGAINST ON THE BASIS OF SOURCE OF PAYMENT, BUT WE DO NOT AGREE THAT IT IS APPROPRIATE TO REGULATE PRIVATE BUSINESS BY DICTATING ADMISSION POLICIES WITH RESPECT TO MEDICAID ADMISSIONS. WE RECENTLY SENT LETTERS TO STATES AND NURSING HOMES REMINDING THEM OF THIS REQUIREMENT. FINALLY, WE BELIEVE THAT IT IS TIME FOR STATES TO SHARE EQUALLY IN THE COSTS OF SURVEYING FACILITIES THAT PARTICIPATE IN THE MEDICAID PROGRAM. WE CURRENTLY PAY 75 PERCENT OF THOSE COSTS. THE ORIGINAL PURPOSE OF THE ENHANCED PAYMENT WAS TO HELP STATES DEVELOP STRONG AND VIABLE SURVEY AGENCIES. THIS GOAL HAS LONG SINCE BEEN REALIZED.

WE ARE COMMITTED TO CAREFUL AND ORDERLY CHANGES IN OUR REGULATIONS OF NURSING HOMES. WE RECOGNIZE THAT BOTH DEFINING AND ASSURING QUALITY CAN BE ACCOMPLISHED ONLY THROUGH THE COOPERATIVE SPIRIT AMONG CONGRESS, THE ADMINISTRATION, THE PROVIDER COMMUNITY AND CONSUMERS. WE BELIEVE THAT TOGETHER WE CAN MAKE THE APPROPRIATE IMPROVEMENTS IN OUR QUALITY ASSURANCE SYSTEM. I CAN ASSURE YOU OF THE ADMINISTRATION'S COMMITMENT TO DO THE VERY BEST POSSIBLE JOB THAT WE CAN TO REACH OUR SHARED OBJECTIVES.

I WOULD BE GLAD TO ANSWER ANY QUESTIONS YOU MAY HAVE.

Senator MITCHELL. The next witness is Mr. Karl Yordy, Director of Division of Health Care Services, Institute of Medicine of the National Academy of Sciences.

Mr. Yordy, welcome. Let me restate for you and all subsequent witnesses the committee's rules. Your written statement will be inserted in the record in full. We ask that you summarize your written statement in your oral remarks, keeping them within five minutes. This green light will be on for the first four minutes; the orange light tells you that you have a minute to go; and the red light tells you your time is up.

STATEMENT OF KARL D. YORDY, DIRECTOR OF DIVISION OF HEALTH CARE SERVICES, INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMY OF SCIENCES, WASHINGTON, DC

Mr. YORDY. Thank you, Mr. Chairman. I am delighted to be here today to describe to you the report of the Institute of Medicine completed in 1986 by a distinguished committee, chaired by Dr. Sidney Katz. And Dr. Katz has consulted with me in the preparation of this testimony and is sorry he cannot be present today.

The Institute of Medicine was asked by the Health Care Financing Administration to undertake this extensive review of nursing home regulation after Congress had expressed strong concern about certain proposed changes in Federal policies. There are many major modifications in the system for regulating nursing homes that should improve the quality of care and quality of life for nursing home residents that are recommended in this report.

The committee found that, while many nursing homes are providing very adequate care, there are other Government certified nursing homes in which individuals have received very inadequate care that is likely to hasten the deterioration of their health. The apparent inability of the previous regulatory system to improve or eliminate substandard facilities is the underlying circumstance that prompted this study.

I would like to now highlight some of the recommendations in this comprehensive report. It is always difficult in a few minutes to summarize something that has many components, but I will mention some of the key recommendations.

First, the committee does not——

Senator MITCHELL. I don't want you to feel so constrained that you can't get your points across. You are a very important witness. If you need a few more minutes, you go ahead and take them.

Mr. YORDY. Thank you, Mr. Chairman. I appreciate that. My father always said I spoke too fast; maybe that will help some, too.

Senator MITCHELL. In this case, speed up. [Laughter]

Mr. YORDY. First, the committee does not think that maintaining separate criteria for skilled nursing facilities and intermediate care facilities is justifiable. The levels of disability and services required by residents in intermediate care facilities are similar to those in skilled nursing facilities and need for supervision of aids by skilled RNs and licensed practical nurses is important in all facilities. The committee also recommends that the standards be completely overhauled to focus primarily on the appropriateness of care actually being provided to residents and the directly observed effects of that care on residents, rather than on the potential capability or intent to provide adequate care.

The committee recommends that all nursing homes be required to make standard assessments of all residents on admission and periodically thereafter, and to record the data in a standard way in the official medical records. This standard resident assessment data will give inspectors an objective basis for comparison of quality. More effective and valid regulation will be facilitated, a powerful means for identifying deficient homes will be provided, and the management of nursing homes will be improved.

Other important recommendations concerning the performance criteria component of the regulatory process are: rewriting many of the existing conditions in order to make them more resident-centered and outcome-oriented; giving additional emphasis to residents' rights by raising them from a standard to a condition of participation; requiring training for nurse's aides; prohibiting discrimination against residents supported by Medicaid; and strengthening the social service staffing requirements.

Turning now to the survey process that is used to identify deficiencies, the committee made a number of recommendations designed to deal effectively with problems with the existing survey process. Among these recommendations are: making the timing of the surveys more flexible and less predictable; instituting a two-stage survey process based on the standard resident assessment system that would use the first stage to screen for problem institutions that would then receive a second, more detailed visit; and encouraging the States to use positive incentives by recognizing and rewarding superior performance.

And the third component of regulation is enforcement, to assure compliance by unsatisfactory facilities. To deal with problems in inadequate enforcement, the committee recommends that the Medicaid legislation be amended to authorize a standard set of intermediate sanctions that can be used by both States and the Federal Government.

These should include ban on admissions, civil finds, receivership, and emergency authority to close facilities and transfer residents. Authority should be provided to impose severe sanctions on the small proportion of facilities that are chronic violators. Moreover, for the really bad facilities, the legislation should be amended to make the appeals process less attractive.

While effective regulation is essential, it is not sufficient to assure quality of care. Other important factors are consumer involvement, community involvement within nursing homes, positive motivation of nursing home staffs, and a number of recommendations were made by the committee along those lines. The committee also recommends that the Ombudsman Program, which is authorized by the Older Americans Act, be strengthened both by amending the legislation and by recommending that the Administration on Aging give it much stronger and more effective leadership.

Finally, the committee identified a number of issues that need further study, including methods and amounts of payments for nursing homes for care of residents eligible for support under the Medicaid Program, policies affecting the supply of nursing home beds in the context of the growing demand for all types of long-term care services, and policies concerning the training and qualifications of all staff in nursing homes.

I have summarized briefly the main points in a very comprehensive report. The members of the committee who did this study would be very pleased to see the serious attention that is being given to the recommendations by the Congress, the Executive Branch, and consumer and industry groups.

This attention is a well-deserved reward for their hard work. Thank you very much, Mr. Chairman. I would be glad to answer any questions you have.

Senator MITCHELL. Would you describe the approach advocated by the Institute in removing the distinction between skilled and intermediate care facilities? And specifically, you recommend transition to another system of classification, and do you think those alternatives are well enough developed to be implemented today?

Mr. YORDY. The committee felt that objective review of the distinctions between skilled nursing homes and intermediate care facilities, as they are used by the several States—as you were indicating in your discussion with Dr. Roper—seems to indicate that that distinction is without meaning in its practical application.

The standards that the committee would advocate be applied are those standards which, in fact, it is recommending in its report; and it has laid out a comprehensive blueprint for what those standards should be. There are a number of components of this improved regulatory system that obviously will take some work to get in place. So, this is something that you couldn't do tomorrow, but that clearly is the direction in which the committee believes that public policy for nursing homes ought to be moving.

Senator MITCHELL. You were present during Dr. Roper's testimony, and you heard the last questioning that I engaged in regarding this problem of preference given to private pay over Medicaid patients. Would you favor a proposal to simply mandate taking of all patients regardless of their status in that regard?

Mr. YORDY. That was the committee's recommendation.

Senator MITCHELL. Yes. That there not be—

Mr. YORDY. That you not be able to discriminate on the basis of Medicaid status.

Senator MITCHELL. Do you see that as a problem?

Mr. YORDY. To the extent that it is a problem, I think the committee would have said that that is a problem that needs to be put forcefully forward and dealt with. To say it is a problem and to say therefore you won't do it is to avoid the problem that was identified by the committee.

Senator MITCHELL. Thank you very much, Mr. Yordy.

The committee has performed a valuable service, not only to the elderly but to the entire country, and we thank you for your testimony here today.

Mr. YORDY. Thank you, Senator.

Senator **Mitchell**. Senator Durenberger.

Senator **Durenberger**. Mr. Chairman, I certainly agree that this is a contribution that many of us have waited for and all of us appreciate deeply. And it is another one of the very fine contributions of the National Academy and particularly of the Institute of Medicine.

Senator **Mitchell**. Thank you very much, Mr. Yordy.

[The prepared written statement of Mr. Yordy follows:]

Statement by Karl D. Yordy
before the Subcommittee on Health of the
Senate Finance Committee,
Hearing on Quality of Long-Term Care
April 28, 1987

Mr. Chairman and members of the committee. My name is Karl Yordy. I am Director of the Division of Health Care Services at the Institute of Medicine of the National Academy of Sciences. I am pleased to have the opportunity this afternoon to tell you about the study of nursing home regulation, completed in 1986 by a distinguished committee of the Institute of Medicine chaired by Dr. Sidney Katz. This statement has been prepared in consultation with Dr. Katz, who regrets that he cannot be present today.

In this statement I will describe the highlights of this detailed and comprehensive report. The study is the product of the hard work and dedication of the committee--a list of whose names are attached. The committee benefited from the able assistance of David Tilson, Staff Director, and other Institute of Medicine staff.

The Institute of Medicine was asked by the Health Care Financing Administration to undertake this extensive review of federal and state regulation of nursing homes after Congress had expressed strong concern about proposed changes in federal policies. The study committee was composed of 20 people with diverse backgrounds, professional training, and experience. They produced a report that recommends profound changes in the system for regulating nursing homes. The recommendations were supported by all members of the study committee. It is the committee's firm belief that if these recommendations are implemented by the Congress, the Executive Branch, and the states, the quality of care and quality of life for many thousands of nursing home residents will improve substantially.

While many of the 15,000 nursing homes participating in the Medicaid and Medicare program provide residents with appropriate care and considerate support, the committee found that in many other government-certified nursing homes, individuals receive very inadequate--sometimes shockingly deficient--care that is likely to hasten the deterioration of their physicial, mental, and emotional health. The apparent inability of the current regulatory system to improve or eliminate substandard facilities is the underlying circumstance that prompted this study.

Federal policies that guide the current regulation of nursing homes are relatively recent. Although the Medicare and Medicaid were approved in 1965, the regulations for skilled nursing facilities and intermediate care facilities were not issued in final form until 1974. From the outset, it was recognized by most interested parties that the regulations were seriously flawed. Moreover, they were administered and enforced very unevenly by the states. Proposals were made to modify them in the late 1970s, but they were not approved; and the regulations remain today much as they were when originally issued.

The main purpose of current federal nursing home regulations is to ensure that nursing home residents receive adequate care in a safe, clean facility and that they are not deprived of their civil rights. The regulations consist of three interrelated components: performance criteria (standards), a monitoring process by the states, and enforcement policies and procedures to assure compliance with the standards. The three components should be thought of as analogous to the legs of a three-legged stool: all are essential. There are major problems with the three components of the regulations, but most are remediable and the committee has recommended remedies that will work.

Performance criteria are called "conditions of participation" and "standards" in the regulations. There are two sets of criteria, one for skilled nursing facilities and another for intermediate care facilities. The committee does not think that maintaining two sets of criteria is justifiable. They also find that the underlying logic of the current criteria is unsound. The criteria are based on the assumption that the potential capability and written intent of the facility to provide appropriate care is sufficient to ensure that adequate care is actually being provided. The committee believes that the standards need to be completely overhauled to focus primarily on the appropriateness of the care actually being provided to residents and the directly observed effects of their care on residents, rather than on a facility's apparent capacity to provide care and its written intent to comply with the standards, as is currently the case. In addition, important performance criteria need to be added dealing with quality of care, quality of life, and minimum training requirements for the primary caregivers, namely, the nurse's aides who provide perhaps 90 percent of the hands-on care to residents.

It is the committee's recommendation to do away with the two levels of care and to require all nursing homes to adhere to a single set of upgraded standards. The committee was aware that 43 percent of all nursing homes are now intermediate care facilities, and that this recommendation may entail added costs, at least in some states. The evidence is strong that this recommendation is necessary to ensure that adequate quality of care and life is provided to residents in ICFs. The levels of disability and services required by residents in intermediate care facilities are similar to those in skilled nursing facilities; and need for supervision of aides by skilled RNs and licensed practical nurses is important in all facilities.

The next major recommendation is far reaching in importance. The committee recommends that all nursing homes be required to make standard assessments of all residents on admission and periodically thereafter, and to record the data in a standard way in the official medical records. Standard resident assessment data across facilities will establish norms that are currently not available (descriptions of services and well-being for residents who have similar characteristics). This resident assessment data will give inspectors an objective basis for comparison of the quality of care, also of the functional aspects of quality of life. More effective and valid regulation will be facilitated and a powerful means for identifying deficient homes will be provided. Such assessment will also give nursing home managers a useful tool that most do not now have. Competent assessment of each resident's functional, medical, mental, and social status is essential to plan a care program individually tailored to the resident's needs. Moreover, the introduction of this system is likely to have a positive effect on the attitudes and behavior of nursing home staff at all levels.

Other important recommendations concerning the performance criteria are to add new conditions of participation on quality of care and quality of life, to rewrite many of the existing conditions in order to make them more resident-centered and outcome-oriented, to give additional emphasis to residents' rights by raising them from a standard to a condition of participation, to require training for nurse's aides, to prohibit discrimination against residents supported by Medicaid, and to strengthen the social service staffing requirement.

Let us now turn to the second leg of the three-legged stool--the processes used to monitor the performance of nursing homes. The monitoring activities include:

- Survey certification inspections of each nursing home at least once a year, conducted by staff of the licensure and certification staff, and primarily focused on the capacity of the facility;
- "inspection of care" reviews conducted either by the state Medicaid agency, the state licensure and certification agency, or a professional review organization;
- investigations of complaints by residents, staff, families of residents. ombudsmen, or other third parties. (Complaints cover resident abuse, inadequate care, violations of residents' rights, or other types of unacceptable behavior by nursing home staff or management. Complaints often involve violations of federal conditions of participation or standards.)

The committee identified needs for changes in current regulations, policies, and procedures governing the current monitoring processes. First, major changes in the process are needed as a result of the previously recommended changes in performance standards. Second, changes are needed to deal with serious problems in relationship between the federal and state monitoring functions. Third, changes are required because of serious limitations in the ability of federal and state regulatory agencies to carry out their responsibility -- primarily inadequate funding to provide sufficient numbers of appropriately-qualified, properly-trained, and adequately-supervised surveyors.

Finally, changes are needed with regard to the following operational issues:

Predictability. Nursing home operators can usually predict the timing of an annual survey because certification is in effect for exactly 12 months. Thus, an operator of a substandard facility can hire extra staff, stock up, improve menu, clean up, bring the records up to date, and take other necessary action to bring the facility into temporary compliance.

Inefficiency. All nursing homes, regardless of their past record of compliance, are surveyed in the same way. A more efficient process would permit the survey agency to spend more time in poor facilities than in good ones.

Paper compliance. Compliance is frequently determined on the basis of record reviews rather than direct observation.

Insensitivity to resident needs. The current survey process makes no allowance for the substantial diversity among residents and among facilities. All skilled nursing facilities and all intermediate care facilities are surveyed in the same way.

Inconsistency. States may vary greatly in the ways that they conduct surveys. Substantial inconsistencies exist in findings and judgments of individual surveyors within states and across states.

Isolation from related monitoring processes. Only 17 states combine or relate the findings of inspection of care reviews with the survey certification practice. In some states, there is little or no sharing of information or coordination of activities between the survey process and the processes for monitoring and investigating complaints.

Variable state regulatory capacity. There are very large differences in the level of funding and staffing, the types and numbers of personnel used, and the length of time spent in inspecting facilities.

The committee made recommendations designed to deal effectively with each of these problems. They recommend making the timing of the surveys more flexible and less predictable. They recommend a two-stage survey approach that is based on installation of the standard resident assessment system discussed earlier. A relatively short, standard survey would be conducted by observing and talking to a case-mix-referenced sample of resident--and staff--using an instrument that relies on key indicators. If the results of the standard survey indicate that quality of care and quality of life are satisfactory, the facility would be certified. If the standard survey uncovers problems, an extended survey--longer and more detailed--would be conducted. The committee recommends that the survey process be integrated with inspection of care, and be coordinated with the complaint program. They also recommend that HCFA encourage the states to use positive incentives by recognizing and rewarding superior performance.

A substantial effort will be necessary to ensure that the instruments and protocols are valid and reliable and that the surveyors be properly trained in their use. The committee recommends that HCFA assist the states in these areas and insist that states perform adequately.

The committee also believes it is important that federal surveyors inspect state-owned facilities to ensure that the same performance standards be observed by state-owned facilities as are required for privately-owned facilities.

The third leg of the three-legged regulatory stool is enforcement. It is clear that even with improved standards and more effective monitoring procedures, performance of marginal or unsatisfactory facilities is unlikely to improve unless compliance with the standards is effectively enforced. The committee found that inadequate enforcement seems to be a problem everywhere. In order to remedy the problem changes must occur in (1) federal and state attitudes toward enforcement, as reflected in the regulations, (2) federal rules and procedures regarding enforcement, (3) state variations in enforcement authority, policies, and procedures, and (4) inadequate federal and state resources for enforcement.

To deal with these problems the committee recommends that HCFA revise its enforcement guidelines to the states to:

- specify that survey agency personnel not be used as consultants to providers with compliance problems;
- specify how to evaluate plans of correction and what constitutes an acceptable plan of correction;
- specify the circumstances under which formal enforcement action should be initiated, and how they should be undertaken;
- require that states have formal enforcement procedures and mechanisms.

The committee recommends that the Medicaid legislation be amended to authorize a standard set of intermediate sanctions that can be used by both state and federal governments. This should include ban on admissions, civil fines, receivership, and emergency authority to close facilities and transfer residents. Authority to impose severe sanctions on chronic violators should also be provided. They estimated that perhaps 10-15 percent of facilities fall into this category of repeat violators. Present statutory authority is not adequate to deal with these facilities. Moreover, for the really bad facilities, the legislation should be amended to make the appeals process on sanctions less attractive. Finally, the committee recommends that HCFA strengthen enforcement capabilities.

While effective regulation is essential, it is not sufficient to ensure adequate quality of care and quality of life in nursing homes. Other important factors are: consumer involvement; community involvement within nursing homes; positive motivation and technical competence of ownership, management and staff; and a professional climate that will attract highly motivated, ethical, and well-qualified staff (supported by the industry and by educational and professional institutions).

The committee recommends that the ombudsman program, which is authorized by the Older Americans Act, be strengthened both by amending the legislation and by recommending that the Administration on Aging give it much stronger and more effective leadership. The committee offered suggestions in the other areas, including the introduction of incentives for rewarding consistently high quality care--for example, preference to institutions with a good record when awarding certificates of need for constructing new facilities or expanding existing ones.

Finally, the committee identified issues that need further study; the scope and design of information systems needed to regulate nursing homes effectively and to facilitate development of sound policies for long-term care; policies governing the method and amounts of payment to nursing homes for care of residents eligible for support under the Medicaid program; policies affecting the supply of nursing home beds in the context of the growing demand for all types of long-term care services; regulatory policies concerning the training and qualifications of all staff in nursing homes; minimum staffing patterns needed to provide adequate care; and policies governing construction for new nursing homes, specifically, the proportion of single rooms that should be required.

I have summarized briefly the main points in a very comprehensive report. The committee and staff worked very hard to make the report as thorough, thoughtful, and responsible as possible. Throughout, the principal concern is for the nursing home residents, a segment of the population which often cannot speak effectively for itself.

I will be pleased to answer questions concerning the report and its recommendations.

Thank you.

Attachment

INSTITUTE OF MEDICINE

Committee on Nursing Home Regulation

CHAIRMAN
Sidney Katz, M.D., Associate Dean of Medicine, Brown University

Carl E. Adams, M.D., National Health Corporation

Allan Beigel, M.D., Professor of Psychiatry, Vice President for University Relations and Development, University of Arizona

Judith F. Brown, R.N., ARA Living Centers

Patricia A. Butler, J.D.,(private practice) Boulder,CO

Iris Freeman, Director, Nursing Home Residents' Advocates

Barry J. Gurland, M.D., Director, Columbia University Center for Geriatrics and Gerentology

Charlene A. Harrington, Ph.D., R.N., Associate Professor, School of Nursing, University of California at San Francisco

Catherine Hawes, Ph.D., Research Triangle Institute

Rosalie Ann Kane, D.S.W., The Rand Corporation

Judith R. Lave, Ph.D., Professor of Health Economics, University of Pittsburgh

Maurice I. May, Chief Executive Officer, Hebrew Rehabilitation Center for Aged

Dana L. Petrowsky, Chief, Division of Health Facilities, Iowa State Department of Health

Sam Shapiro, Professor, Department of Health Services Administration, The Johns Hopkins University, School of Hygiene and Public Health

Peter W. Shaughnessy, Ph.D., Director, Center for Health Services Research, University of Colorado Health Sciences Center

June L. Sides, Consultant, Regency Health Care Centers, Inc.

Helen L. Smits, M.D., Yale University School of Medicine, Department of Epidemiology and Public Health

David Alan Wagner, Vice President for Planning and Marketing, Trimark Corporation

Bruce C. Vladeck, Ph.D., President, United Hospital Fund of New York

May Louise Wykle, Ph.D.,R.N., Associate Professor, Frances Payne Bolton School of Nursing, Case Western Reserve University

Senator **Mitchell**. The next panel will include three witnesses: Barbara Frank, the Associate Director of the National Citizens' Coalition for Nursing Home Reform; Aaron Johnson, Chairman of the State Medicaid Directors' Association of the American Public Welfare Association and the Commissioner of the Georgia Department of Medical Assistance; and Paul Willging, Executive Vice President of the American Health Care Association.

Welcome, Ms. Frank and gentlemen, and we look forward to your testimony. We heard me describe the committee's rules to the previous witness. I ask that you adhere to them, please. We will hear from you in the order that you appear on the witness list. That means, Ms. Frank, you may begin and welcome. We look forward to hearing from you.

STATEMENT OF BARBARA W. FRANK, ASSOCIATE DIRECTOR, NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM, WASHINGTON, DC

Ms. **Frank**. Good afternoon, Senator. I am Barbara Frank, with the National Citizens' Coalition for Nursing Home Reform. Senator Mitchell, we applaud your leadership on this important nursing home reform initiative, and we urge the members of the Senate Finance Committee to pass quality care legislation this year.

We have lamented the problems in nursing homes for decades. The studies and reports identifying problems and recommending action fill our library. Despite all this study, all the research and demonstrations, the Federal regulations defining standards of nursing home care have not been revised since they were written over a decade ago; and although changes have been made in the survey process, the regulatory system has not been strengthened significantly since it was first established.

The Institute of Medicine's 1986 report, "Improving the Quality of Care in Nursing Homes," offers a new opportunity for action. It calls on the Federal Government to upgrade nursing home standards and improve its monitoring and enforcement efforts.

A year after the release of the IOM's report, HHS has yet to respond to the study it commissioned, and it has yet to implement any of the report's recommendations. The proposals HHS is considering fall far short of needed improvement. Current outcomes in nursing homes point to the need for change. Consumers are looking to Congress to provide a statutory base for these changes and direct HHS in this regulatory action.

There is no longer an excuse for inaction. We know how to provide good nursing home. There are nursing homes in every State which provide decent and humane care. Many States have enacted sound laws and regulations to improve nursing home care. The solutions to problems in nursing homes are available.

Since the IOM's report was released, a coalition of 20 national organizations representing consumers, providers, health care professionals and nursing home workers has met regularly to analyze its recommendations and achieve nursing home reforms. As you can imagine, as such a diverse coalition of national organizations, we have our differences; but we have discovered that our differences are not as great as our common goal of nursing home improvement.

We have worked hard to hammer out a sensible and constructive set of concensus recommendations, a package of essential reforms which we urge you to include in quality care legislation this year. The recommendations, which I have here, have been endorsed by 50 national organizations, and we submit them for the record. They address 12 key issues: upgrading resident's rights, strengthening the Ombudsman program, access to quality care regardless of source of payment, elimination of the artificial distinction between skilled and intermediate care facilities, Federal direction for resident assessment conducted by a multidisciplinary team of health and mental health professionals, nurse aid training, mandatory training and competency testing for all newly employed nurse's aides within the first two months of employment, and the requirement that nurse's aides be competent to perform duties, nurse staffing, upgrading the level and number of nursing staff required commensurate with residents' care needs and accuity levels, social services, a comprehensive program to meet the social and emotional needs of residents and their families provided by a qualified professional, mental health services as needed by nursing home residents, improvements in the survey and certification process, enforcement of laws and regulations mandating that the States utilize intermediate sanctions and alternates to decertification, Medicaid payment, public access to information about the scope and extent of Medicaid coverages of services and items, Medicaid coverage for services required by Medicaid standards, and coordination between the quality assurance and the payment programs.

We must all work continually to assure that every person living in a nursing home receives good care and enjoys a good quality of life. We support your proposal to establish a nursing home commission to continue to address ongoing issues needing long-term attention.

This year, we have the opportunity to make significant strides, to upgrade the minimum standards across the board, and put mechanisms in place to monitor nursing home conditions and enforce standards. Such changes can help each and every nursing home resident. There is no doubt that these proposals will cost money, but as a humane and caring society, we must be clear about our priorities and our principles.

We must be willing to spend basic dollars for basic services, to provide acceptable quality of care and quality of life for nursing home residents. Our recommendations build upon the important work of the Institute of Medicine.

The recommendations have been tried and tested. Although these recommendations are not new, what is new is that the parties concerned are united in our call for action.

We pledge our support for quality care legislation this year. We implore you, Senator Mitchell: Don't add this hearing record to a dusty pile of studies and reports that have no results. Take this opportunity to make a significant contribution to public policy for the sake of this generation of nursing home residents and the next.

Senator MITCHELL. Thank you, Ms. Frank.

[The prepared written statement of Ms. Frank follows:]

TESTIMONY OF BARBARA FRANK
for the
National Citizens' Coalition for Nursing Home Reform

April 28, 1987

Before the Subcommittee on Health of the Senate Finance Committee

My name is Barbara Frank and I represent the National Citizens' Coalition for Nursing Home Reform. Our organization has 300 member groups advocating with and on behalf of nursing home residents in 45 states, for better nursing home conditions and for a strengthened consumer voice in development of public policy on nursing home issues.

We are here today to applaud your leadership for nursing home reform, Senator Mitchell, and to urge the members of the Senate Finance Committee to pass quality care legislation this year. We have lamented the problems in nursing homes for decades. The studies and reports identifying problems and recommending action fill our library.

Despite all this study, all the research and demonstrations, the federal regulations defining standards of nursing home care have not been revised since they were written over a decade ago and, although changes have been made in the survey process, the regulatory system has not been strengthened significantly since it was first established.

The Institute of Medicine's 1986 report, Improving the Quality of Care in Nursing Homes, offers us a new opportunity to take action. The IoM Committee spent over two years reviewing problems and solutions. It collected, in one place, some of the best thinking and best practices in nursing homes and in regulatory programs and recommends that the federal government upgrade its requirements for nursing homes and improve its monitoring and enforcement efforts.

The IoM's recommendations are in keeping with the Tenth Circuit Court's ruling in 1985 in Smith v. Bowen, that the federal government has a duty to ensure that nursing home residents receive quality care -- and that it has failed in this duty. The court ordered the Department of Health and Human Services to remedy this failure to assure quality care through better regulation, but the federal government has yet to satisfy the court. A year after the release of the Institute of Medicine report, HHS has yet to respond to the study it commissioned, and has yet to implement any of the report's recommendations. The proposals HHS is considering fall far short of needed improvements. Consumers are looking to Congress to provide the statutory base for nursing home reforms and direct HHS in its regulatory action.

There is no longer an excuse for inaction. The state of the art on good nursing home care is available -- there are good nursing homes in every state which provide decent and humane care to those who depend on them. There are state inspectors throughout this country who do a good job of monitoring the care nursing home residents receive. Many states have enacted sound laws and regulations to improve nursing home care. The solutions to problems in nursing homes are available to us. Many are within our reach. Yet it seems easier to lament the problems than to act on solutions.

Today I have the privilege of reporting on the work of a coalition of 20 national organizations who have labored for over a year to develop a public policy agenda for nursing home improvement. This public policy agenda has been endorsed by more than fifty national organizations who have pledged their support to its passage in this year's legislative session.

Our collaborative effort brought together a unique coalition of consumer organizations, nursing home owners and operators, health care professionals, and nursing home workers. We are united in our conviction that the time has come to act on nursing home reform legislation. We endorse your efforts for legislative reform and urge you to enact the nursing home quality care amendments before your committee.

Our coalition of 20 national organizations has met regularly since the Institute of Medicine report's release, as part of NCCNHR's Campaign for Quality Care, launched in June, 1986 to generate implementation of nursing home reforms. We recognized that while we all supported the goals of the IoM report, we needed to analyze them to determine how to achieve them. We had very practical concerns about how to implement the recommendations in a manner which would actually work.

As you can imagine, as such a diverse coalition of national organizations, we have our differences, but we have discovered that our differences are not as great as our common goal of nursing home improvement. We have worked hard to hammer out a sensible and constructive set of recommendations -- a package of essential reforms -- which we urge you to include in quality care legislation this year.

Attached to my testimony is a copy of the Campaign for Quality Care's consensus positions for nursing home reform this year. Our report also contains "supplemental positions" in areas in which we could not reach consensus, areas in which we anticipate future discussion and action. Our consensus papers address 12 key issues, all essential, we believe, to assuring basic quality care for nursing home residents:

* Residents' rights -- including the right to participate in decision-making within the nursing home, the right to visitors, the right to participate in a decision to be moved to another facility, and the right to full consideration of grievances.

* Ombudsman Program -- including access for the ombudsman to residents, to the facility, and to residents' records for purposes of complaint investigation; and cooperation between the state regulatory agency and the ombudsman program.

* Equal Access to Quality Care -- including the right to be informed of legal rights as a Medicaid beneficiary, protection from transfer solely for conversion from private pay to Medicaid, and the right to an acceptable quality of services, regardless of source of payment.

* Elimination of the SNF/ICF Level of Care Distinction -- and replacement with a single designation "nursing home" with a single set of standards incorporating and upgrading current skilled nursing facility standards.

* Resident Assessment -- including a standard data set of information reviewed for each resident to form the basis of care planning, incorporating the assessments of each of the health and mental health care disciplines potentially providing care to a resident.

* Nurse Aide Training -- including mandatory training and competency testing for all newly employed nurse aides within the first two months of employment and the requirement that nurse aides be competent to perform duties.

* Nurse Staffing -- including upgrading the level and number of nursing staff required commensurate with residents' care needs and acuity levels.

* Social Services -- including a comprehensive program of services to meet the social and emotional needs of residents and their families, provided by a qualified professional.

* Mental Health Services -- including an assessment of residents' needs, referral to appropriate caregivers or delivery of mental health care within the nursing home.

- Survey and Certification -- including improvements in the survey process, specifications for survey team composition and training of surveyors, cooperation among state agencies and between the state and federal governments.
- Enforcement of Laws and Regulations -- including the mandate that states develop intermediate sanctions and alternatives to decertification; that the federal government support states in the development and use of these sanctions and monitor state enforcement activities.
- Medicaid Payment -- including public access to information about the scope and extent of Medicaid coverage of services and items; inclusion as allowable costs of services required by Medicaid standards, and coordination between quality assurance and payment programs.

There is no doubt that these proposals will cost money. But as a humane and caring society we must be clear about our priorities and our principles. We must be willing to spend basic dollars for basic services.

It does cost money to make sure that nurses' aides have the basic training to know how to care for residents without injuring residents or themselves. It does cost money to make sure that nursing homes have nurses -- isn't that why we call them nursing homes? It does cost money to make sure that nursing homes have social workers and mental health supports, that residents receive care to match their needs based on individualized assessments rather than artificial "levels of care." It does cost money to support the quality assurance system, the recourse for citizens to assure that their health, safety, welfare, and rights are protected.

We must all be clear that the expenditures under consideration are the bare minimum needed to provide acceptable quality of care and quality of life for nursing home residents.

The National Citizens' Coalition for Nursing Home Reform is aware that the solutions to complex nursing home problems are not simple -- that while the reforms contained in our consensus package could result in significant improvement, ongoing systemic issues, first addressed in the consensus papers, will continue to need attention over the long term. We support Senator Mitchell's proposal to establish a Commission as a forum for continued examination and discussion of these critical issues:

* Support for nursing home workers, including decent wages, benefits and working conditions;
* Access to quality health care for all citizens regardless of ability to pay;
* Attention to the "quality of life" needs of nursing home residents;
* Community involvement to open doors and prevent isolation surrounding nursing home residents;
* Recognition of nursing home residents' rights as citizens, as people, and as consumers of nursing home care, including their right to self-determination and to participation in decisions affecting their home;
* Commitment of public resources to provide decent and humane care for the old, the sick, and the disabled; and assurance that dollars allocated for nursing home care are spent on delivering good care to residents;
* Public recognition of the importance of helping older persons continue to maintain themselves to the maximum degree possible through rehabilitative and restorative care.

We realize that we must all work continually to assure that every person living in a nursing home receives good care and enjoys a good quality of life. This year we have the opportunity to make significant strides, to upgrade the minimum standards, across the board and put mechanisms in place to monitor nursing home conditions and enforce standards. Such changes can help each and every nursing home resident.

Our recommendations build upon the important work of the Institute of Medicine. The recommendations have been tried and tested. They have worked in good nursing homes. They have worked in effective state agencies. They have been recommended by government studies and demonstrations.

We have worked hard to develop this consensus because we believe that the participation of all who will breathe life into these recommendations is necessary if they are truly to work for the benefit of nursing home residents. Although these recommendations are not new, what is new is that the parties concerned all stand before you united in our call for action. We pledge our support to achieve passage of quality care legislation this year. We implore you not to add this hearing record to a dusty pile of studies and reports that had no results. We implore you to take this opportunity to make a significant contribution to public policy, for the sake of this generation of nursing home residents and the next. Thank you.

Senator Mitchell. Mr. Johnson, welcome. We look forward to your testimony.

STATEMENT OF AARON J. JOHNSON, CHAIRMAN, STATE MEDICAID DIRECTORS' ASSOCIATION OF THE AMERICAN PUBLIC WELFARE ASSOCIATION, AND COMMISSIONER, GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE, ATLANTA, GA

Mr. Johnson. Thank you, sir. Good afternoon. I am Commissioner of the Georgia Department of Medical Assistance and Chairman of the State Medicaid Directors' Association, which is affiliated with the American Public Welfare Association. I have come today to present the views of State Medicaid agencies on the quality of care provided in nursing homes and specifically to comment on the recommendations of the insightful Institute of Medicine Study, including the quality of care in nursing homes, released earlier last year.

The Directors of State Medicaid Programs hold a unique position as financers and regulators of nursing homes. Currently, approximately half of all nursing homes' revenues comes from Medicaid. At the same time, nearly half of all Medicaid funds are sent on finance and care provided in long-term care institutions.

We understand what a difficult task it is to ensure that quality care is provided in nursing homes. While I have submitted more detailed testimony regarding the State Medicaid Directors' views on the IOM Study, let me focus on a few key issues.

We agree completely with the general thrust of the report in focusing on patient needs and the care they are actually provided rather than evaluating the nursing homes' capability, that is the capability to provide the care.

As the payers of these services, we are far more concerned with the outcome than the process. A refocusing of the conditions of participation toward patient care and away from facility physical plant and the current paperwork requirements will greatly enhance the ability of the review process to assure quality care.

The States believe that the IOM recommendations regarding monitoring of nursing home performance will lead to a more efficient and effective use of the limited resources available. We believe the current system contains a great deal of waste. In particular, we support the use of a standard surveying instrument with a sampling of patient assessments for most homes where resources should be focused on the problem facilities by using extended surveys when problems are identified through the standard survey.

In the past, requirements have been such that 100 percent of the reviews have led to unnecessary penalties to States without any proof that these reviews benefit nursing home residents. One of the more controversial recommendations of the IOM was to do away with any distinction between skilled nursing facilities and intermediate care facilities.

The State Medicaid Directors agree that such a distinction is often hard to discern; however, the proposal holds some potential problems. The first is that because the proposed single classification would require 24-hour nursing services, the overall cost of nursing care will go up. This increase in cost should not be ignored.

Second, setting a single level of care standard which requires 24-hour nursing could have an adverse effect on residents who require less care. The question is: Will residents who only require 15 hours of nursing care a week become ineligible for nursing home service under Medicaid?

Obviously, this is not the intent of the recommendation, but recent trends in the administration of the Medicare Program have shown that meeting the level of care provided is a crucial factor in determining eligibility. Clarification of the intent of this recommendation is necessary should the committee pursue it.

Finally, we oppose the IOM recommendations to withhold Federal Medicaid dollars for States that have substandard survey and classification programs. It seems illogical to penalize the activities of one State agency—survey and certification—by taking funds from another agency—Medicaid.

In most States, Medicaid Directors have little or no influence over the survey and certification process. We would, however, also oppose any effort to sanction the survey and certification agency. How can improvement occur in the process with fewer resources?

The States believe that there are already adequate negative incentives in place to ensure that substandard surveying does not become a chronic problem in any State.

Mr. Chairman, I hope my comments will be of use to you and other members of the committee. And I am free to answer any questions.

Senator MITCHELL. Thank you, Mr. Johnson.

[The prepared written statement of Mr. Johnson follows:]

TESTIMONY OF
AARON J. JOHNSON

GOOD MORNING MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE. I AM AARON J. JOHNSON, COMMISSIONER OF THE GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE AND CHAIRMAN OF THE STATE MEDICAID DIRECTORS' ASSOCIATION OF THE AMERICAN PUBLIC WELFARE ASSOCIATION.

I HAVE COME TODAY TO PRESENT THE VIEWS OF THE STATE MEDICAID AGENCIES ON THE QUALITY OF CARE PROVIDED IN NURSING HOMES, AND SPECIFICALLY TO COMMENT ON THE RECOMMENDATIONS OF THE INSIGHTFUL INSTITUTE OF MEDICINE STUDY, IMPROVING THE QUALITY OF CARE IN NURSING HOMES, RELEASED EARLY LAST YEAR.

THE DIRECTORS OF THE STATE MEDICAID PROGRAMS HOLD A UNIQUE POSITION AS FINANCIERS AND REGULATORS OF NURSING HOMES. CURRENTLY, APPROXIMATELY HALF OF ALL NURSING HOME REVENUES COME FROM MEDICAID. WE UNDERSTAND WHAT A DIFFICULT TASK IT IS TO ENSURE THAT QUALITY CARE IS PROVIDED IN NURSING HOMES.

WE BELIEVE THAT THE INSTITUTE OF MEDICINE HAS GONE A LONG WAY TOWARDS EXPLAINING THE CURRENT PROBLEMS AND PROPOSING REASONABLE SOLUTIONS. OVERALL WE AGREE WITH THE GENERAL THRUST OF THE REPORT IN FOCUSING ON PATIENT NEEDS AND THE CARE THEY ARE ACTUALLY PROVIDED, RATHER THAN SIMPLY LOOKING AT THE NURSING HOMES' CAPABILITIES AS CURRENT REQUIREMENTS DO. WE ALSO APPLAUD RECOMMENDATIONS TO MAKE THE MONITORING PROCESS MORE EFFICIENT BY ALLOWING FOR SAMPLING IN REVIEWS RATHER THAN REVIEWING ALL PATIENT ASSESSMENTS. TOO MANY RESOURCES ARE WASTED IN THE

CURRENT SYSTEM IN WHICH 100 PERCENT REVIEW OF PATIENT RECORDS IS REQUIRED IN ALL FACILITIES, WHETHER THEY HAVE A HISTORY OF PROVIDING GOOD OR POOR CARE.

I WOULD LIKE TO COMMENT ON THE STUDY'S RECOMMENDATIONS.

CHANGES IN FEDERAL CERTIFICATION CRITERIA

THE STATE MEDICAID AGENCIES BELIEVE THAT ELIMINATING THE DISTINCTION BETWEEN A SKILLED NURSING FACILITY (SNF) LEVEL OF CARE AND AN INTERMEDIATE CARE FACILITY (ICF) LEVEL OF CARE IS DESIRABLE, BUT HAS SOME POTENTIAL PROBLEMS. THE REASON FOR ELIMINATING THIS DISTINCTION AS PRESENTED IN THE IOM STUDY IS THAT THERE IS OFTEN NO CLEAR DIFFERENCE BETWEEN THE ICF OF CARE PROVIDED TO SNF RESIDENTS IN ONE STATE AND ICF RESIDENTS IN ANOTHER. IT IS CERTAINLY TRUE THAT INCONSISTENCIES EXIST BETWEEN THE ICF CARE PROVIDED IN ONE STATE AND THE ICF CARE IN ANOTHER, JUST AS THE CARE RECEIVED BY A SNF RESIDENT IN ONE STATE IS DIFFICULT TO DIFFERENTIATE FROM THE ICF CARE IN ANOTHER STATE. WE DO HAVE TWO CONCERNS, HOWEVER, REGARDING THIS RECOMMENDATION.

FIRST, SINCE THE STUDY CALLS FOR SETTING A SINGLE LEVEL OF CARE EQUAL TO THE CURRENT SNF LEVEL, REQUIRING 24-HOUR NURSING SERVICES, IT WILL SIGNIFICANTLY INCREASE THE COST OF NURSING HOME CARE PROVIDED UNDER THE MEDICAID PROGRAM. IF THE OBJECTIVE OF QUALITY CARE CAN BEST BE MET IN THIS MANNER IT SHOULD BE PURSUED, BUT WE SHOULD NOT CLOSE OUR EYES TO THE FINANCIAL IMPLICATIONS.

PERHAPS A REASONABLE APPROACH WOULD BE TO RELATE THE PROFESSIONAL STAFFING TO THE NEEDS OF THE PATIENTS BASED ON THE RESIDENT ASSESSMENT. THIS COULD RELATE PROGRAM COSTS TO PATIENT NEEDS. AS SERVANTS OF THE PUBLIC IT IS OUR JOB TO RECOGNIZE ALL THE COSTS AND BENEFITS, AND WE MIGHT BE BUYING MORE THAN IS NECESSARY WITH ONE LEVEL OF HIGH OPTION CARE.

SECOND, SETTING A SINGLE LEVEL OF CARE STANDARD WHICH REQUIRES 24-HOUR NURSING COULD HAVE AN ADVERSE EFFECT ON RESIDENTS WHO REQUIRE LESS CARE. WILL RESIDENTS WHO ONLY REQUIRE 10 HOURS OF NURSING CARE A WEEK BECOME INELIGIBLE FOR NURSING HOME SERVICE UNDER MEDICAID. I MENTION THIS IN THE CONTEXT OF THE CURRENT TREND IN WHICH THE ASSESSMENT OF THE LEVEL OF CARE A PERSON NEEDS HAS BECOME A CRUCIAL FACTOR IN THEIR ELIGIBILITY. THE MEDICARE PROGRAM IS THE BEST EXAMPLE. OBVIOUSLY, THE INTENT OF THE BILL IS NOT TO THROW ALL THE "TRUE" ICF PATIENTS OFF MEDICAID. IT IS IMPORTANT, HOWEVER, TO MAKE IT CLEAR THAT THE IMPLEMENTATION OF THIS PROVISION WILL NOT RESULT IN SUCH A POLICY. WE DO NOT WANT TO GO BACK TO THE EARLY YEARS OF THE PROGRAM WHEN ONLY THE INDIVIDUALS NEEDING HIGHER CARE SNF SERVICES WERE COVERED.

OUR GOAL SHOULD BE PROFESSIONAL STAFFING ADEQUATE TO DELIVER THE CARE NEEDED BY THE RESIDENTS IN NURSING FACILITIES. THERE IS A SIGNIFICANT DIFFERENCE BETWEEN THE STAFFING NEEDS OF REHABILITATION PATIENTS VERSUS LOW-CARE RESIDENTS. WE WOULD

SUGGEST A VARIABLE STAFFING REQUIREMENT BASED ON THE AMOUNT OF PROFESSIONAL STAFF NECESSARY TO PROMOTE RECOVERY AND ENHANCE THE QUALITY OF LIFE FOR EACH RESIDENT. THIS MIGHT PROVE LESS EXPENSIVE AND AVOID ANY ADVERSE IMPACT ON RECIPIENTS CURRENTLY IN NEED OF ICF CARE.

REQUIRING STANDARDIZED RESIDENT ASSESSMENTS, WHICH ARE CONDUCTED AT REASONABLE INTERVALS, IS A GOOD IDEA. WE BELIEVE THE BENEFIT FROM SUCH A PROCEDURE IS CLEAR IN TERMS OF ACCURATELY ASSESSING A PATIENT'S CONDITION OVER TIME AND CORRECTLY ASSESSING THE QUALITY OF CARE PROVIDED BY DIFFERENT NURSING FACILITIES. THE RECOMMENDATION ALSO CALLS FOR THE ASSESSMENT TO BE CONDUCTED BY A REGISTERED NURSE WHO HAS RECEIVED "APPROPRIATE TRAINING". WE ASSUME THAT THIS MEANS STANDARD TRAINING PROVIDED IN A REGISTERED NURSING PROGRAM, RATHER THAN OTHER SPECIAL TRAINING.

THE STATE MEDICAID AGENCIES STRONGLY AGREE WITH THE RECOMMENDATION THAT THE CONDITION OF PARTICIPATION BE REWRITTEN TO FOCUS ON THE CARE ACTUALLY PROVIDED RATHER THAN THE CARE A FACILITY IS CAPABLE OF PROVIDING. AS THE PAYORS OF SERVICES WE ARE FAR MORE CONCERNED WITH OUTCOME THAN WITH PROCESS. WE BELIEVE THAT THE CURRENT CONDITIONS OF PARTICIPATION ARE MORE CONCERNED WITH PHYSICAL PLANT AND PAPERWORK THAN WHETHER THE PATIENT IS RECEIVING QUALITY CARE. A REFOCUSING OF THE REQUIREMENTS WILL GREATLY ENHANCE THE REVIEW PROCESS.

Elevating the quality of life, as well as the quality of care, to a condition of participation for nursing facilities in the Medicaid program is an excellent idea. Such a standard will necessitate more involvement of families and communities in the operation of nursing facilities on an ongoing basis.

The quality of life involves social interaction beyond the care provided by the facility. Also, increased involvement by families and communities will lead to a better quality of care because of the implicit increase in the oversight of such care.

We agree with the recommendation to increase the importance of residents' rights by elevating them to a condition of participation.

Consolidating several current conditions of participation regarding the general administration of nursing facilities into a single condition is a good idea. It will maintain the requirements for effective and efficient management of nursing facilities, yet it will deemphasize the importance of these activities relative to patient care.

We support the recommendation that institutional policies and practices should not discriminate based on source of payment for admission, transfer, discharge or services. Medicaid directors oppose all forms of discrimination against Medicaid recipients.

STATES PAY FOR WHAT IS NECESSARY TO PROVIDE QUALITY CARE TO NURSING HOME RESIDENTS. STATES ALSO ESTABLISH AND ENFORCE PROVISIONS TO PROTECT RESIDENTS AGAINST PRACTICES SUCH AS THE SEGREGATION OF MEDICAID RESIDENTS AND UNEQUAL CARE AND TREATMENT.

SOME MEDICAID DIRECTORS ARE CONCERNED, HOWEVER, ABOUT THE POSSIBLE INTERPRETATION OF THE WORD "SERVICES". MANY STATES ARE CONCERNED THAT THIS WOULD RESULT IN PAYING AMENITIES DESIGNED TO ATTRACT PRIVATE PAYING RESIDENTS AND NOT FOR IMPROVED QUALITY OF CARE. WE SUGGEST THAT RATHER THAN USE THE WORD SERVICES, "MEDICAID-RELATED SERVICES" OR "QUALITY OF CARE" BE USED.

MONITORING NURSING HOME PERFORMANCE

AS I MENTIONED BEFORE, THE STATES SUPPORT MOST OF THE IOM RECOMMENDATIONS REGARDING THE MONITORING OF NURSING HOME PERFORMANCE BECAUSE THEY WILL LEAD TO A MORE EFFICIENT AND EFFECTIVE USE OF THE LIMITED AVAILABLE RESOURCES. THE CURRENT SYSTEM CONTAINS A GREAT DEAL OF WASTE. OUR VIEWS ON SOME OF THESE RECOMMENDATIONS FOLLOW.

ESTABLISHING UNANNOUNCED SURVEYS FOR NURSING FACILITIES NOT EARLIER THAN 9 MONTHS, NOR LATER THAN 15 MONTHS, AFTER THE PREVIOUS SURVEY IS A GOOD IDEA. IF THESE SURVEYS ARE TO PROVIDE PROPER OVERSIGHT IT SEEMS LOGICAL THAT A REGULAR 12 MONTH REVIEW PATTERN BE AVOIDED. I WOULD POINT OUT THAT ALTHOUGH FACILITIES

MAY CURRENTLY ESCAPE EXPOSURE FOR PHYSICAL DEFICIENCIES THAT ARE EASILY CORRECTED BEFORE A SURVEY. POOR CARE PROVIDED TO A PATIENT OVER AN EXTENDED PERIOD CANNOT BE QUICKLY REMEDIED. WE BELIEVE THAT THE 12 MONTH SURVEYS HAVE BEEN CATCHING SUCH PROBLEMS.

DEVELOPING TWO SURVEYS, A STANDARD SURVEY AND AN EXTENDED ONE, IS A GOOD WAY TO FOCUS RESOURCES ON PROBLEM AREAS. CURRENTLY, THE SAME EFFORT IS MADE WHETHER SURVEYING A GOOD FACILITY OR A BAD ONE. PROBLEMS CAN BE READILY IDENTIFIED BY RELYING ON KEY INDICATORS IN THE STANDARD SURVEY, AND IT IS ALSO TRUE THAT SUCH A SURVEY CAN TELL IF GOOD QUALITY CARE IS BEING PROVIDED.

USING A SAMPLE, RATHER THAN 100 PERCENT, OF THE RESIDENT ASSESSMENTS WITHIN A FACILITY FOR THE STANDARD SURVEY IS AN EXCELLENT IDEA. AGAIN, PROFESSIONAL SURVEYORS CAN QUICKLY IDENTIFY THAT POSSIBLE DEFICIENCIES EXIST IN A FACILITY FROM A SAMPLE. IN CASES WHERE POOR CARE IS IDENTIFIED THE REQUIREMENT FOR AN EXTENSIVE REVIEW OF ALL RESIDENT ASSESSMENTS IS APPROPRIATE.

BY REPLACING THE CURRENT REQUIREMENTS OF 100 PERCENT REVIEW IN EVERY FACILITY REVIEW, STATE AND FEDERAL GOVERNMENTS WILL BE ABLE TO SAVE A SIGNIFICANT AMOUNT OF FUNDS WHILE IN NO WAY JEOPARDIZING THE PATIENTS' HEALTH OR WELL BEING.

We also agree with the recommendation that all survey protocols should meet certain standards and provide consistent results in the evaluation of different facilities.

We support 100 percent federal funding for the first three years of the new survey and certification process. While the monitoring changes will reap financial savings for state and federal governments, the transition may be expensive.

In order for the change to occur smoothly the additional federal funds are needed for a limited time. We are particularly pleased with this suggestion at the same time the administration has proposed to eliminate all enhanced funding for the Medicaid program.

Recently, and without legislation, HCFA wrote into regulation a new and much more narrow definition of "skilled professional medical personnel" for whose services states receive 75 percent federal funding. This sudden change in definition after 20 years effectively reduces federal funding to states. The states believe that enhanced federal funding is an appropriate means of establishing program priorities.

Combining the inspection of care (IOC) and survey and certification process is basically a sound idea, but state Medicaid agencies do have some reservations. Because both the

IOC AND SURVEY AND CERTIFICATION PROCESS ARE CARRIED OUT AT DIFFERENT TIMES BY TEAMS WITH SIMILAR PROFESSIONAL PERSONNEL. COMBINING THE TWO WILL SAVE STATE AND FEDERAL FUNDS FOR PERSONNEL AND TRAVEL, AND IT WILL REDUCE THE PAPERWORK REQUIREMENTS FOR THE NURSING FACILITIES.

DESPITE THESE POTENTIAL BENEFITS FROM COMBINING THE TWO PROCESSES, THE STATE MEDICAID AGENCIES HAVE SOME RESERVATIONS ABOUT THE PROPOSAL. LET ME EXPOSE SOME BIASES OF STATE MEDICAID DIRECTORS. WE TEND TO THINK THAT IOC TEAMS, UNDER OUR CONTROL, FOCUS MORE ON THE CARE PATIENTS ARE RECEIVING AND WHETHER THEY ARE APPROPRIATELY PLACED, WHILE SURVEY AND CERTIFICATION TEAMS, OFTEN NOT UNDER OUR CONTROL, EMPHASIZE THE PHYSICAL PLANT OF A NURSING FACILITY.

IN THE OPINION OF THE STATE MEDICAID DIRECTORS, CONTROL OF THE SURVEYING ACTIVITY WOULD BECOME PARTICULARLY IMPORTANT BECAUSE IT WOULD BE THE ONE REVIEW OF HOW MEDICAID DOLLARS ARE BEING SPENT. WHILE THE IOM STUDY PROPOSES COMBINING THESE ACTIVITIES, THE RESPONSIBILITY FOR THE QUALITY OF LIFE AND NURSING CARE RECEIVED BY MEDICAID RESIDENTS IS THE RESPONSIBILITY OF OUR AGENCY. WE NEED A DIRECT RELATIONSHIP WITH THIS ACTIVITY IN ITS ENTIRETY IF WE ARE TO HAVE THIS RESPONSIBILITY AND PAY FOR THE CARE.

AS ADMINISTRATORS OF THIS MULTI-BILLION DOLLAR PROGRAM WE FEEL MORE CONFIDENT WHEN WE HAVE CONTROL OVER THE REVIEW OF THE QUALITY OF SERVICE OUR CLIENTS ARE BEING PROVIDED. THIS IS NOT TO SAY SURVEY AND CERTIFICATION PERSONNEL DO A BAD JOB, ONLY THAT IN MANY STATES WE ARE NOT CURRENTLY INVOLVED IN THAT PROCESS AND GIVING UP OUR REVIEW TOOL, THE IOC, MAKES SOME OF US UNEASY.

SEVERAL STATES HAVE ALREADY COMBINED THEIR IOC AND SURVEY AND CERTIFICATION EFFORTS AND ARE PLEASED WITH THEIR APPROACH. PERHAPS THE SOLUTION TO THE STATE MEDICAID DIRECTORS' CONCERN LIES WITHIN EACH STATE'S ABILITY TO WORK TOWARDS AN APPROPRIATE BALANCE AS TO WHAT THE PURPOSE OF THE SURVEYING EFFORT IS AND HOW DIFFERENT AGENCIES WILL INTERACT. I DO NOT BELIEVE THAT ANY LEGISLATION AT THE FEDERAL LEVEL CAN ANSWER THIS QUESTION, BUT I WANTED TO BRING IT TO YOUR ATTENTION.

WE ARE OPPOSED TO THE RECOMMENDATION THAT MEDICAID MATCHING FUNDS BE WITHHELD FROM STATES THAT ARE FOUND TO HAVE INADEQUATE SURVEY AND CERTIFICATION EFFORTS. AS WAS DESCRIBED ABOVE, MOST STATE MEDICAID AGENCIES DO NOT ALSO CONDUCT THE SURVEY AND CERTIFICATION EFFORT IN THEIR STATE. WHILE WE GENERALLY OPPOSE ALL FISCAL SANCTIONS, THIS PROPOSAL SEEMS PARTICULARLY ILLOGICAL SINCE AN AGENCY, WOULD BE SANCTIONED FOR ACTIVITIES OVER WHICH IT HAS NO CONTROL.

WE WOULD ALSO OPPOSE ANY EFFORT TO SANCTION THE SURVEY AND CERTIFICATION AGENCY. HOW CAN IMPROVEMENT OCCUR WITH FEWER RESOURCES?

THE STATES BELIEVE THAT THERE ARE ALREADY ADEQUATE NEGATIVE INCENTIVES IN PLACE TO ENSURE THAT SUBSTANDARD SURVEYING DOES NOT BECOME A CHRONIC PROBLEM IN ANY STATE. WE SUPPORT FEDERAL "LOOK-BEHIND" REVIEWS THAT CHECK STATE EFFORTS, AND STATE MEDICAID AGENCIES ARE ALWAYS SUBJECT TO PENALTIES IN BENEFIT DOLLARS IF THESE REVIEWS SHOW THAT INADEQUATE CARE IS BEING PROVIDED.

ENFORCEMENT PROCESS

WE GENERALLY SUPPORT THE RECOMMENDATIONS REGARDING THE ENFORCEMENT PROCESS, PARTICULARLY TO PUT IN PLACE STATE AND FEDERAL AUTHORITY TO USE INTERMEDIATE SANCTIONS TO ENFORCE COMPLIANCE AGAINST NURSING FACILITIES. MANY STATES HAVE ALREADY ESTABLISHED INTERMEDIATE SANCTIONS AT THE STATE LEVEL, BUT FEDERAL CONFIRMATION OF THIS ACTIVITY CAN PROVIDE ADDITIONAL SUPPORT TO THE STATES. THE CURRENT FEDERAL PENALTIES THAT CALL FOR EXPELLING A PROVIDER FROM THE PROGRAM AND NOTHING LESS ARE UNREALISTIC BECAUSE THEY POTENTIALLY HURT THE PATIENT AND NOT THE PROVIDER.

I WOULD ADD ONE WORD OF CAUTION REGARDING THE STRENGTHENING OF SANCTIONS AND TIGHTENING OF THE APPEALS PROCESS. GIVE STATES

DISCRETION IN HOW THESE ARE APPLIED. IF INTERMEDIATE SANCTIONS ARE MEANT TO GIVE STATES MORE LATITUDE IN DEALING WITH PROVIDERS, THEN PARTICULAR SANCTIONS SHOULD NOT BE TIED, MANDATORILY TO SPECIFIC VIOLATIONS.

REIMBURSEMENT

I WOULD LIKE TO COMMENT BRIEFLY ON AN AREA WHICH THE IOM STUDY INTENTIONALLY DID NOT DEAL WITH -- REIMBURSEMENT. THIS IS A VERY IMPORTANT ISSUE BECAUSE THE REIMBURSEMENT SYSTEM CAN HAVE A TREMENDOUS IMPACT ON THE ALLOCATION OF RESOURCES WITHIN A FACILITY, AND THEREFORE, THE TYPE OF CARE PROVIDED TO PATIENTS.

MANY STATES HAVE BEEN TRYING A VARIETY OF NEW APPROACHES TO INCREASE THE RESOURCES DEVOTED TO PATIENT CARE, WHILE CONTROLLING OVERALL COSTS. CASE-MIX REIMBURSEMENTS HAVE BEEN THE CENTER OF THESE NEW APPROACHES.

WE AGREE WITH THE STUDY'S RECOMMENDATION THAT THE REIMBURSEMENT POLICIES OF STATES MUST UNDERGO FURTHER STUDY. WE DO NOT HAVE ALL THE ANSWERS NOW. THE STATES ARE CURRENTLY TRYING DIFFERENT CASE-MIX APPROACHES AND LEARNING A GREAT DEAL. THIS INFORMATION IS BEING SPREAD AMONG THE STATES IN A VARIETY OF WAYS INCLUDING CONFERENCES OF THE STATE MEDICAID DIRECTORS' ASSOCIATION.

WE WOULD NOT AGREE, AS SOME GROUPS HAVE RECOMMENDED, THAT CASE MIX REIMBURSEMENT BE MANDATED UPON THE STATES. NOT ENOUGH IS YET KNOWN ABOUT SUCH SYSTEMS TO SUPPORT SUCH A MANDATE, AND IN OUR VIEW IT IS UNLIKELY THAT SUCH A MANDATE ON ALL MEDICAID PROGRAMS WOULD EVER BE JUSTIFIED. CONGRESS HAS HAD THE WISDOM TO REALIZE THAT ALTHOUGH A DRG SYSTEM OF REIMBURSEMENT IS CORRECT FOR MEDICARE IT IS NOT APPROPRIATE TO MANDATE SUCH A PAYMENT SYSTEM ON ALL STATE MEDICAID PROGRAMS. THE SAME IS TRUE OF CASE-MIX SYSTEMS.

MR. CHAIRMAN I HOPE MY COMMENTS WILL BE OF USE TO YOU AND THE OTHER MEMBERS OF THE SUBCOMMITTEE IN YOUR CONTINUED DELIBERATIONS REGARDING IMPROVING THE QUALITY OF CARE IN NURSING HOMES. THE STATE MEDICAID DIRECTORS STAND READY TO ASSIST YOU IN ANY WAY WE CAN. THANK YOU FOR INVITING ME TO TESTIFY TODAY. I WOULD BE HAPPY TO ANSWER ANY QUESTIONS YOUR MIGHT HAVE.

Senator **Mitchell**. Mr. Willging, welcome again. We look forward to your testimony.

STATEMENT OF PAUL WILLGING, EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION, WASHINGTON, DC

Mr. **Willging**. It is a pleasure to be here, Mr. Chairman, to deal today with what is indeed a most critical issue; and as one can see by the makeup of this panel, an issue equally critical to Government providers of health care services in nursing homes and to consumer advocates.

Indeed, I think this hearing and the events that have transpired over the course of the past week, Mr. Chairman, are to some extent a watershed in this debate over quality of care. I have appeared on many occasions with Ms. Frank, usually on opposite sides of the table. This is the first time, I believe, that as a result of the concensus activity spearheaded by the National Citizens' Coalition, we have been able to appear on the same side of the table, dealing with some unanimity on the same issues.

Fifteen years ago, Mr. Chairman, I doubt that could have happened. Senator Frank Moss and the Select Senate Committee on Aging pointed to some clear issues with respect to quality of care in nursing homes, issues which galvanized this Congress and galvanized American attention.

I think the times have clearly changed. As Dr. Roper suggested, the Institute of Medicine marked the improvement that has taken place in the quality of care provided in nursing homes. The Institute of Medicine, at the same time, pointed out that there was indeed room for improvement. But I think it is interesting to note, Mr. Chairman, that the debate has moved to a new plateau. We are not talking any more about basic deficiencies in terms of life safety.

We are moving into a discussion of quality of life, of the rights of residents, of assessments, plans of care, of the need to provide mechanisms for nursing home residents to break out of the isolation they so often feel through a strengthened Ombudsman Program. We are talking about changing the focus of surveys away from input and process toward the care actually provided patients.

I think that itself marks a new era in our discussions. And that is appropriate. I think in years past and perhaps rightly so, we devoted almost exclusively our attention to the regulatory and enforcement mechanisms required.

We do not object. Indeed, I think it is only fair to admit the need in years past for a strong regulatory environment dealing with long-term care. I think it appropriate though that, within now the parameters of the regulatory mechanisms put in place, we are talking more intensely about the services provided within those parameters.

I think that is the underlying theme of the exercise engaged in over the past few months, culminating in a group of papers signed off on now by 54 organizations in Washington and across the country. I think that is the underlying theme in the legislation that you are going to propose, Senator, dealing with this new era, this new plateau, upon which the debate is taking place.

That is not to say that there are not still issues. We generally agree to the thrust of your legislation, but we still have in the areas of nurse's aide training, staffing and sanction some difficulties. We do feel that the role of the Federal Government is to assure the efficacy and the effectiveness of those activities that the State Governments should be more involved in setting the specific parameters.

And you, Mr. Chairman, have raised perhaps one of the most troublesome issues in the area of long-term care and nursing home care—the issue of access—an issue that cuts across three different planes: access to any kind of a bed for any kind of a patient, regardless of the source of payment; access for heavy care patients and facilities; and access in many States to the Medicaid patient, as far as long-term care is concerned.

It is a critical issue, but it is an issue that does not, Mr. Chairman, lend itself to a simple solution. It is an issue, I would suggest, we might wish first to understand and perhaps then to act. And I agree to the provisions in your legislation, which would establish a study commission to get to the root cause of this problem because, although I am often accused of inevitably raising the issue of reimbursement, access and reimbursement are inextricably intertwined. And until we understand the why's and wherefores of that nexus, we will not do any more than come up with simplistic solutions which will exacerbate, not solve, the problem.

I would like to close on two points, one of which I have already mentioned. We have indeed, I think, reached a new watershed event in this discussion, and I am looking forward to continuing this debate within the parameters of cooperation and collaboration, rather than within the parameters of confrontation and adversarial relationships.

And second, I think it absolutely critical, as you have done in your legislation, Mr. Chariman, to recognize the relationship between quality and reimbursement. We do nothing more than offer a series of false promises to the American people if we suggest to them that we can add new services, new staffing, new requirements to a sector of the health care delivery system, and that there is indeed a free lunch and that we need not pay for them.

I can agree wholeheartedly with Ms. Frank, who suggests that it is time that we bring together the courage to provide the resources to do what it is we all wish to do. State government providers, consumer advocates provide the highest quality care to America's nursing home residents. Thank you, Mr. Chairman.

Senator MITCHELL. Thank you, Mr. Willging.

[The prepared written statement of Mr. Willging follows:]

Paul R. Willging, Ph.D.

American Health Care Association

Good morning. I am Paul Willging, Executive Vice President of the American Health Care Association (AHCA), the largest association representing America's long term care providers. AHCA's membership exceeds 9,000 long term care facilities which care for about 900,000 residents each day.

The quality of long term care has come a long way in the past 15 years. Fifteen years ago, Senator Frank Moss, Chairman of the Special Committee on Aging, held a series of Congressional hearings that indicated serious problems in the provision of long term care in nursing homes. Most of the problems aired by Senator Moss and the Special Committee are now, thankfully, behind us. Nursing homes have made tremendous progress in providing competent basic health care and in assuring safe and sanitary facilities.

The Institute of Medicine (IOM) report on the quality of nursing home care, released in February of last year, made note of the progress which has been achieved in improving the provision of long term care. The Institute study, which was originally proposed by Congressional leaders, revealed that the nursing home industry has made great strides in delivering quality care, but that room for improvement still remains. Quality of life for residents and the process by which nursing home services are reviewed by responsible government agencies were highlighted as areas that needed greater attention. The study emphasized that nursing home residents need, and deserve, choices and more consideration of their rights as residents and as Medicare/Medicaid beneficiaries. The report recommended that caretakers and nurse aides should have the training required to improve the care they provide to residents. In the area of monitoring nursing home performance, the IOM suggested quicker, more coordinated action when problem situations are found and a revamped system of nursing home inspection that focuses on patient care, not on paperwork.

The American Health Care Association applauded the Institute of Medicine study when it was released. The study thoroughly examined a myriad of issues involved in the state and federal regulatory system and came up with common sense and progressive recommendations, setting a framework for action.

The year since the IOM report was released has been a watershed for nursing home quality and for enforcement of federal and state regulations. The Health Care Financing Administration has refocused its survey and certification process. Nursing home inspectors in every state have learned to orient their surveys away from paperwork and toward the actual care delivered to nursing home residents and the outcome of that care. Surveyors are interviewing residents in order to learn if the quality of their care is acceptable and whether they are satisfied with their nursing home.

This new survey system has led to tough, detailed, patient-oriented surveys. Facilities that appear clean and keep good records are being told that that is not enough. If patients are becoming less ambulatory, developing infections or show other signs of what surveyors call "negative outcomes," the facility is finding itself in trouble.

HCFA has also put into place a comprehensive enforcement system to deal with providers that do not meet program requirements. No longer may state survey agencies dawdle while they try to convince a provider to improve care and services. If any condition of participation is out of compliance, the provider must be terminated from the Medicare or Medicaid program within 90 days. If patient health and safety is placed in jeopardy, a termination action must take place within 23 days, 5 days in federal "look-behind" situations. In the first year these procedures were put in place, at least 44 skilled nursing facilities and 14 intermediate care facilities were "terminated." In one year, there were 28 "immediate and serious jeopardy" or "fast track" terminations.

One of the most important events since the release of the IOM study has been the effort by consumer, professional and provider groups to reach consensus on comprehensive legislation needed to move forward the reforms recommended by IOM. The results of that year-long effort were released last week and we are proud to have been a part of that ambitious undertaking. The "consensus papers" represent the best thinking by those involved in both public policy and the actual delivery of long term care services.

Since the Institute of Medicine released its report, there have been a number of legislative proposals which have sought to implement its major recommendations. Some of these proposals are consistent with many of the "consensus papers." No proposal, however, in our view, Mr. Chairman, is more constructive in moving forward the intent of the IOM report and more in line with the "consensus papers" than your bill. Your legislation deals with issues paramount to quality care: the training of nurse aides; reviewing the ability of facilities to perform basic quality assurance activities; developing a national data system for resident assessment; and directing the development of quality care standards in such areas as nutrition and skin care.

I would like to discuss a few of the critical issues that arise in almost any discussion of the quality of long term care. First, I would like to comment on nurse aide training. We agree with your approach, Mr. Chairman, that state governments should have the primary responsibility for developing programs for the training and competency testing of these important caregivers. At least 20 states have mandated nurse aide training. These programs vary from state to state because there are different needs within states which have led to different types of programs. We disagree with some additional requirements, notably one which would specify the number of hours and the timing of training programs. At least 20 states have mandated nurse aide training. These programs vary from state to state because there are different needs within states which have led to different types of programs.

There has also been controversy over what type of federal role is needed in directing state activities to sanction providers. We favor the approach taken in the "consensus papers" that states be required to have at their disposal an array of enforcement actions and that federal and state agencies should coordinate their enforcement actions. The "consensus papers" also recommend that HCFA give guidance and technical assistance to states. We strongly oppose the federal government directing states on how to sanction facilities. States know what type of authority they need for both licensing and certification purposes. We believe that federal mandates could tie the hands of state agencies and, in the long run, interfere with the basic goal -- achieving compliance or getting the provider out of the program.

The Health Care Financing Administration already has very powerful methods to police providers. Since the IOM study was released, HCFA has implemented new procedures for terminating Medicare and Medicaid providers that fail to meet program regulations and new federal intermediate sanctions which prohibit new admissions to problem facilities.

Perhaps the most costly and yet most important aspect of your bill, Mr. Chairman, deals with the nurse staffing in long term care facilities. We do not object in principle to requiring every Medicaid-certified nursing home in the country to have around-the-clock licensed nurses, either registered nurses (RNs) or licensed practical nurses (LPNs), so long as qualified nurses are available and the nursing home is guaranteed reimbursement for the additional staff.

We do not favor federal 24-hour registered nurse coverage in all facilities, at least not yet, for three reasons. First, we believe the price tag for such a requirement is prohibitively high. Second, we believe that licensed practical and vocational nurses do provide competent and caring nurse coverage, sufficient for the health and welfare of residents in many facilities. Third, nursing homes are facing a severe and growing problem of attracting registered nurses. Nursing students are still inadequately prepared for service in long term care facilities. Round-the-clock registered nurse coverage is simply not a practical option.

Revisions in the survey and certification process as contained in your bill, Mr. Chairman, and other legislative proposals are long overdue. The inspection process, to be meaningful, must focus on resident care, and the people conducting the inspections must be knowledgeable about nursing home care and the needs of the elderly and chronically ill. From a provider's viewpoint, the worst thing that can happen during an inspection is to be confronted with someone who does not know the subject matter or the inspection process. We enthusiastically support your provision, Mr. Chairman, for a competency test for surveyors. We also agree that the federal government should set constructive guidelines for states to use in carrying out their enforcement activities. While states need the flexibility to react to local needs, greater consistency within and between states is needed in such procedural areas as evaluating plans of correction, investigating complaints and forming special survey teams.

There are two additional changes providers believe are needed in the survey process. Both deal with situations in which providers disagree with survey findings, and neither is addressed in your bill, Senator Mitchell, or any other legislative proposal. First, we believe that each state should be required to develop procedures for handling instances where there is professional disagreement between those giving and those inspecting nursing home care. Unless a facility is facing a serious sanction, it does not have any formal recourse for expressing disagreement with survey findings. These disagreements are occuring more frequently as surveys rightly focus more on patient care. They concern such subjects as the best way to give skin care, whether tube feedings are indicated, and even determining the most up-to-date methods of infection control.

In addition to procedures for handling professional disagreements, we believe that at times a complete new survey may be needed. On rare, but critical, occasions facilities receive inspection reports that are totally out-of-line. We believe that facilities showing appropriate justification should be able to be reinspected by a second state or federal survey team. The findings of both surveys would then be used to determine the facility's compliance with requirements.

One of the most controversial issues raised by the Institute of Medicine study and subsequent legislation is that of nursing home access for Medicaid beneficiaries, especially Medicaid beneficiaries with heavy care needs. Long term care facilities find they must maintain an appropriate balance of Medicaid and private pay patients to maintain their care standards and offset the often inadequate reimbursement they receive for Medicaid patients. There are a number of federal and state policies that cause access problems for Medicaid patients. They include: general bed shortages often perpetuated by state certificate of need (CON) rules; inadequate Medicaid reimbursement rates; and the failure of Medicaid rates to cover the costs of heavy care patients.

The American Health Care Association is committed to the resolution of the access dilemma. But, we believe that the problem of access for Medicaid patients is complex. It is not amenable to simplistic solutions that some have suggested which not only fail to change the causes, but may create or exacerbate other problems. We want to work with Congress, the states, consumer advocacy groups and regulatory agencies to develop together a plan which will lead to access to quality long term health care for all elderly and chronically ill in need of such care, regardless of their source of payment. However, we feel that instituting mandatory Medicaid admission requirements without addressing the adequacy of reimbursment rates would lower the quality of care in facilities or result in a two-class system of facilities for Medicaid and private pay patients.

We believe that your legislation, Mr. Chairman, makes an excellent next step in rationally addressing the problem of access. You would prohibit facilities from using certain admission practices which tend to directly discriminate against Medicaid beneficiaries. Your bill also directs state Medicaid programs to bridge the coverage gap between nursing home admissions and receiving approval for Medicaid eligibility. We also support your provision that would require states to enumerate items and services covered by the Medicaid per diem rate. This measure would enable all interested parties -- providers, consumers and state legislatures -- to acquire and analyze information necessary for developing long-range solutions, such as acuity-based reimbursement systems.

The American Health Care Association believes that the Commission on Long Term Care, which would be established by your legislation, would generate the kind of thoughtful and orderly study and recommendations needed to address the access problem. The Commission could advise Congress on such issues as appropriate staffing, the adequacy of Medicaid reimbursement, and bed supply -- all critical components in the access problem.

But most importantly, Mr. Chairman, your legislation recognizes the critical relationship between quality of care and reimbursement. If Congress is, indeed, committed to improving quality of long term care, it must be equally committed to providing additional federal resources to cover the cost of additional care and services.

Laudable as these quality provisions are, let us not make the mistake of holding out false promises. If we wish to enhance care, let us recognize that there are costs involved in imposing additional requirements on nursing homes and increasing enforcement activities. Even changes in the survey process will result in increased costs. Facilities surveyed by HCFA's revised outcome-oriented survey process report that the deficiencies found when patient care is accurately evaluated can only be corrected with the addition of qualified staff. Without changing a single printed standard, survey teams throughout the country are ordering facilities to increase staff and increase the professional competency of their staff.

In conclusion, I would like to urge the members of this Committee to look seriously at the comprehensive consumer-provider "consensus papers" that present in detail a workable legislative and regulatory proposal that would impact positively on the lives of 1.5 million current and future nursing home residents. This unprecedented consensus of 20 associations has produced what I feel are the most constructive and realistic recommendations on nursing home regulation in more than a decade.

I want to extend to the Committee the assistance of the American Health Care Association in working to implement these important recommendations to improve the quality of long term care.

Senator MITCHELL. I thank all of you for very eloquent, informative statements, and I congratulate you for the work you have done in coming together in this difficult, controversial area.

Now, I want to ask Ms. Frank and Mr. Johnson to comment on the point made by Mr. Willging, which I thought was a very fair point on this question of access and selection of private pay over Medicaid patients. There are two sides to this question as there are on almost all of them. Let me take the other side from the one which I was earlier advocating and say I was representing a nursing home operator and asked you: If we were to adopt the recommendations that Mr. Yordy presented to us prohibiting any discrimination on account of the status of the applicant, what would prevent States from maintaining an overly restrictive control of beds and even lowering Medicaid payment further, if they knew that the private facilities in those States were required to accept Medicaid patients on a first-come, first-served basis, let's say?

How is that fair to the nursing home operator? And why is that not a powerful inducement to the States to take that action, given the fiscal difficulties that all the States are now in the burgeoning costs of Medicaid to them? Ms. Frank, do you want to start with that?

Ms. FRANK. We appreciate your concern about this issue, and we share the concern. We have seen examples of States that have not done their part to support the need for access for Medicaid recipients; and we also recognize that it is a problem that is shared by lots of parties in the system.

It is not necessarily sensible to make Federal policy because you are afraid of what somebody else might do that won't be so good. Sometimes it is important to make Federal policy based on what you know is right.

We have to look at the accountability of health care dollars.

Senator MITCHELL. I agree with you, Ms. Frank, but I am constrained to say that, in addition, prudence dictates that when you adopt Federal policy, you take into account the implications of your action and the possiblity of consequences occurring as a result of that. Don't you agree?

Ms. FRANK. I agree with that, and that puts us all into a position to anticipate both the best and the worst, and then to see what we can do to assure that the worst doesn't occur and that the best does. That is the same situation that we face any time that we try to make changes; there is a potential that that change can go in a direction we don't want. So, we have to all be vigilant to make sure it occurs the way it should.

Senator MITCHELL. Mr. Johnson, do you have a response to that question?

Mr. JOHNSON. Yes, sir, to some extent. Mr. Chairman, I am sure you recognize that, in prior years—let's say as many as maybe five years ago and earlier—we in this country allowed health care costs to just escalate just completely out of sight. Everything that we touched was to some extent regulated, including by the market; but health care costs escalated just completely out of sight, and they are still doing that.

States are good fiscal managers. As a matter, most States can only spend what they take in. It is not a matter of spending, finding some way to get around having to live within your budget. In my State, I cannot spend what is not in my budget. The State cannot spend what the State does not take in in terms of taxes. I don't believe that the States would permit a situation to pertain where residents would not be getting the services which the residents need.

States are close to the residents, close to the citizens. They are closer, I dare say, than many people in Washington.

Senator **Mitchell**. But Mr. Johnson, I don't dispute physical proximity, but the very fact that Federal intervention has occurred is a direct result of the default of States from acting in an area that was peculiarly subject to their regulatory activity over many decades.

And I think there is no disputing the principle that you have suggested, but the reality is that that is what we are doing here. That is why we are here. You certainly concede that, if States had acted in any appropriate manner, there would not have been all of these studies to which Ms. Frank eloquently referred and all of these recommendations and these abuses that have led to the point where now we have this consensus formulation.

Mr. **Johnson**. I agree with what you are saying. The problem with the States has largely been actually getting the hands on the dollars.

Senator **Mitchell**. Yes.

Mr. **Johnson**. And if the States have the dollars available to them, I believe that the States could properly use those dollars.

Senator **Mitchell**. I don't dispute that, but the problem is much more specific. If we pass a law accepting the recommendation that Mr. Yordy made here that mandates—that requires—a nursing home to accept patients on a first-come, first-served basis and prohibits them from taking into account the status of the applicant—that is, whether it is private pay or Medicaid—will that not serve as an inducement to the States to simply lower the Medicaid payments——

Mr. **Johnson**. I understand.

Senator **Mitchell**. And therefore operate to the severe disadvantage of the nursing home operator?

Mr. **Johnson**. I am sorry. In the State of Georgia, and I am sure it is not too much different from other States, there is a patient's bill of rights which requires that the patient not be discriminated against because of his source of payment. Most of the nursing homes in Georgia abide by that bill of rights.

Senator **Mitchell**. Oh, you have a State requirement that charges them?

Mr. **Johnson**. It is a bill of rights which the nursing home association has adopted, and the State also lives by it. We do, as Medicaid representatives.

Senator **Mitchell**. Do you know how many States have a similar requirement, Mr. Johnson?

Mr. **Johnson**. I don't know how many States do it. I get the impression that we are not the only one.

Senator **Mitchell**. Could you try to find out and get back to us with that information?

Mr. **Johnson**. Yes, sir.

[The prepared information follows:]

Bill of Rights for Residents of Long-Term Care Facilities*

Rights

You have the right to:

1. Associate with persons of your choice.
2. Participate in social, family, religious and community activities.
3. Enter and leave facility as you choose.
4. Non-discriminatory admission.
5. Refuse medical treatment, dietary restrictions and medication.
6. Be free from restraints, isolation or restrictions.
7. Not be discharged or transferred against your wishes.
8. Your privacy.
9. Have visitors of your choice.
10. Manage your own financial affairs.
11. Have access to all your personal and medical records.
12. Receive from the long-term care facility written and oral explanation of your rights, including grievance procedure.

Grievance Procedure

If you feel any of your rights have been violated, you may give an oral or written complaint to the:

1. Administrator - who must respond within three business days.
2. State or Community Ombudsman - who must attempt to solve the problem within 10 days.
3. You then have the right to have the issue decided by an impartial referee - jointly chosen by complainant and administrator:
    A. Must hold hearing within 14 days.
    B. Render a decision within 72 hours after hearing.
4. You also have the right to an administrative hearing under Georgia Administrative Procedure Act (Ga. Laws 1964, p. 338) and to file a court action to enforce your rights.

Enforcement

Georgia Department of Human Resources is authorized to:

1. Order facility to discontinue admitting residents until violations have been corrected.
2. Assess civil penalty.

Note: Long-term care facilities include skilled nursing and intermediate care facilities which are often called nursing homes. These are not all of your rights. The written explanation you receive from the facility contains a complete listing.

*Georgia Health Code, Chapter 88.19B (Ga. Laws 1981, p. 143 et seq.)

For additional information on residents' rights in long-term care facilities, contact the Standards and Licensure Section, Office of Regulatory Services, Georgia Department of Human Resources.

Senator MITCHELL. Mr. Willging, do you happen to know?

Mr. WILLGING. There are about half a dozen States, Mr. Chairman.

Senator MITCHELL. About a half dozen?

Mr. WILLGING. About a half dozen. There are States, such as Senator Bradley's, that require a first-come, first-served up to a Statewide average. There are States that have equalized rates as a way of dealing with the access issue. There are States that have essentially put in first-come, first-served.

Senator MITCHELL. Has the possible adverse effect mentioned in my question occurred in those States?

Mr. WILLGING. I think in some States it has; in some States, it hasn't. And once again, one has to look at the environment within which that legislation has been enacted within a specific State.

I take a State just off the top of my head, and off of the piece of paper that I have in front of me, the State of Illinois; and I think it gets to the question that was raised previously, Mr. Chairman: the right of a provider to offer services to a patient population higher than the bare minimum, mandated by Federal and State legislation.

The Medicaid rate in the State of Illinois for a day of SNFF care is $37.30. This is selected data—selected in the sense that it is what came into me, not selected to make my point. The cost per day in the facilities reviewed of providing that day of care is $64.58.

Senator MITCHELL. What State is that?

Mr. WILLGING. This is the State of Illinois. The private pay rate in these facilities in the State of Illinois is $77.36—for a simple reason. These facilities don't wish to provide the kind of care that you can purchase for $37.30. They would prefer to provide the kind of care you can purchase for $65.00. To do that, they have to maintain some form of balance between the private pay and the Medicaid rates.

There is a State—the State of Minnesota—which has equalized rates, and indeed it has not had a dramatically adverse impact, the reason being that the State of Minnesota has traditionally had among the highest rates in the nation for Medicaid.

In the State of Georgia—in my colleague's State—the Medicaid rate is in the 30's. I suspect that a first-come, first-served rule in the State of Georgia would have one of two inevitable impacts, either a major requirement for new appropriations, or a dramatic reduction in the quality of care provided in a number of facilities within the State.

Senator MITCHELL. He has already said there is a rule there in Georgia in effect.

Mr. JOHNSON. We have a patients' bill of rights. And as Medicaid Director, I have very little problem. I do have some now, but I have very little problem with discrimination on the basis of source of pay in the State of Georgia.

Senator MITCHELL. Ms. Frank, let me defer to Senator Bradley to see if he has any questions. Then, when he concludes, you can make whatever point you wished to make.

Senator BRADLEY. Mr. Chairman, I only have one, and I compliment you on holding this hearing. I think it is terribly important. I think home care is clearly a bigger and bigger issue, particularly as people are released from hospitals quicker and sicker. I think some of the things that we see in nursing homes might have applicability to care in the home.

One of the things that I am particularly interested in is that the Older Americans Act now requires an Ombudsman to Look into nursing home quality concerns. Do you on the panel think that home care provided under Medicare should be subject to the same kind of access to an Ombudsman?

Ms. **Frank**. Senator Bradley, I appreciate your question. The nursing home Ombudsman program was established well after the regulatory system for nursing homes was firmly in place, and it was able then to serve as an outside advocate to assure that the regulatory system did its job for nursing home residents. The concept of an Ombudsman for home care is definitely an idea that should be thought about for the future. Right now, the regulatory structure for home care is woefully inadequate, and what we might wind up with is an Ombudsman that serves as a regulator instead of an outside advocate. In the long run also, we are quite well aware that the nursing home Ombudsman program is overwhelmed by too big a job with too little resources.

So, we would advocate strongly that, if there were to be a parallel position, that position would be well enough funded to do its job adequately.

Senator **Bradley**. Mr. Johnson or Mr. Willging?

Mr. **Willging**. I would support that concept. As I indicated in my testimony, Senator, I think the Ombudsman Program is a program that the American nursing home industry supports and supports strongly. It is a critical part of attempts and procedures to make sure that the nursing home patient—in the case of the nursing home Ombudsman Program, and I would say equally so for home care patients—do not face nothing but this sense of isolation when they feel they have problems, when they feel that they need to discuss an issue with someone outside of the environment within which the care is being provided. So, I think that the concept does make sense.

Mr. **Johnson**. I would agree to the concept. It is a good one; it is a situation where part of the problem we deal with is that nursing home residents many times have no one to speak for them. There is not a lot of advocacy on the part of nursing home residents. I believe that the Ombudsman Program could be used to some extent to fill that void.

Senator **Bradley**. What do you think about insisting on federal standards for home health aid training pnograms as another way of improving quality?

Mr. **Johnson**. Oh, yes, sir. There is no way that I would take any stand against training. Training, of course, is important, and it would certainly benefit the program.

Senator **Bradley**. Ms. Frank and Mr. Willging, do you agree?

Mr. **Willging**. I think the issue of adequately trained aides, be they home care aides or nursing home aides, is an important one, one which we certainly support, and I suspect should be supported either in home care or nursing home care. We do feel—and in this regard, I think there is again some concensus—that the training in terms of the specificity—number of hours and specific curriculum content and the like—should perhaps be a State function with broad Federal parameters because the environments are unique State to State, but the concept certainly of training and of competency testing—and the proof of the pudding would be in the competency testing—would be a critical part of the environment, be it home care or nursing home care.

Senator **BRADLEY**. And Ms. Frank?

Ms. **FRANK**. Medicare and Medicaid have a key role in assuring that beneficiaries receive decent quality care. It is impossible to give quality care if people don't know how to do the job. Competency to perform your tasks is the bottom line essential. You can't have good care without people who know how to do the job.

Senator **BRADLEY**. Mr. Chairman, I appreciate the chance to get the opinions of these witnesses.

Senator **MITCHELL**. Thank you, Senator. I would just note that you are correct, Mr. Johnson, that nursing home residents frequently don't have spokespersons but I must say that Ms. Frank is a particularly eloquent spokesperson for them, and I commend you, Ms. Frank. You made a very persuasive and eloquent statement. And Mr. Willging, you are always very informative to this committee, and we are very grateful to you. You are very reasonable and informed.

And Mr. Johnson, we have benefitted greatly from your testimony as well. So, thank you all very much.

The next panel includes Marjory Blood, a member of the National Legislative Council of the American Association of Retired Persons; and Ann Mootz, former Director of the Home Aide Service and United Home Care in Cincinnati, Ohio, appearing on behalf of the National Association for Home Care. Welcome to both of you. Ms. Blood, it is a pleasure to see you again. You are well known in Maine as an eloquent advocate for retired persons; and as always, we welcome you and look forward to hearing from you.

Senator **BRADLEY**. Mr. Chairman, may I submit some questions for these two witnesses for the record? I don't know how much longer I will be able to remain.

Senator **MITCHELL**. Yes, without objection, Senator. Certainly.

STATEMENT OF MARJORY BLOOD, MEMBER, NATIONAL LEGISLATIVE COUNCIL, AMERICAN ASSOCIATION OF RETIRED PERSONS, AUGUSTA, ME

Ms. **BLOOD**. Thank you, Senator Mitchell.

On behalf of more that 25 million members of the AARP, I want to thank you for this opportunity to state the association's views on the need to reform our nation's long-term care quality assurance policies.

We believe that the time is ripe for Congress and the Administration to take action now to improve the quality assurance mechanisms for the delivery of nursing home and home health services. For those who are lucky enough to receive home health care, quality concerns immediately arise.

In contrast to its efforts to constrain coverage, Medicare does little to assure quality or to regulate home care providers. The mechanisms that the Health Care Financing Administration use are weak and, since 1981, only 23 providers have been involuntarily dropped from participation in Medicare.

Quality assurance in the home is of great concern because of the vulnerability of the frail recipients of services from strangers in a location beyond the easy reach of public scrutiny. Additionally, practically no public information is available today on the quality of home care.

The five areas that must be assessed promptly are training of home health aides, intermediate sanctions, the Medicare survey and certification process, consumer grievance mechanisms, and mandatory State licensing.

First, home health aides are generally unskilled, poorly paid. It is essential that these workers be properly trained prior to rendering services, that standards are established to promote competency, and that agencies conduct background checks before allowing aides to enter clients' homes.

Second, with regard to enforcement mechanisms, authorities now only can choose between doing nothing or dropping agencies from participation in the program. A greater range of sanction options needs to be available, including civil fines, receivership, and denials of payments for new admissions. We also support stipulating timetables for correcting deficiencies with a graduated series of more severe sanctions being imposed for continuing noncompliance.

Third, the current process by which providers become certified to receive home health Medicare payments has little or nothing to do with the quality of the care delivered.

Verification that the Medicare conditions of participation are met is based on a check of paper compliance, and clients are rarely interviewed to determine the kind of care actually provided. A patient-based outcome-oriented survey must be put into effect for home health agencies and needs to be conducted more frequently according to client status.

A new section should also be added to the conditions of participation covering patients' rights, and the directory should be made available to the public, specifying which agencies are Medicare-certified, whether they have been cited for any quality-related deficiencies, and whether sanctions have been imposed.

Fourth, recipients of home care services who have been abused or been given substandard care presently have virtually no place to turn other than the formal law enforcement officials. The lack of an organized program to receive and investigate consumer complaints is largely responsible for our almost complete lack of knowledge about what is occurring behind those closed doors.

All home care providers should have written clients' grievance procedures, and States or local communities should be required to implement an advocacy program with enforcement authority to receive and investigate consumer complaints.

Last, we hope this committee is sensitive to the fact that approximately 30 percent of all home health care agencies do not participate in Medicare. Congress must scrutinize the quality of care delivered by these almost totally unregulated agencies and should begin by requiring all States to license home care providers before delivering support or other personal care services.

In the area of nursing home quality, AARP strongly supports the position papers developed by the Campaign for Quality Care in Nursing Homes.

Briefly, similar to the issues raised with home health, mandatory training programs and competency testing for nurse's aides are essential; and the Federal and State Governments must have a broader range of intermediate sanctions and other alternatives to decertification at their disposal, such as civil fines and receivership authority.

All nursing homes should be required to have at least one registered professional nurse on staff 24 hours a day, seven days a week, with appropriate waivers available, and should be required to maintain identical policies and practices regarding admission, transfer, discharge, and Medicaid covered services for all individuals regardless of source of payment.

Finally, the nursing home personal needs allowance should be increased to $35.00 with a cost of living adjustment.

In conclusion, AARP is grateful that members of this committee have chosen to address these important clarity issues. We are particularly pleased about the legislation introduced by Senators Mitchell and Bradley that address almost all of the nursing home and home health quality concerns that we have expressed here. We enthusiastically support both of these bills and offer our resources and assistance to enact those reforms into law this year.

Senator MITCHELL. Thank you very much, Ms. Blood.

[The prepared written statement of Ms. Blood follows:]

Marjory Blood
Member, AARP National Legislative Council

Thank you, Senator Mitchell. My name is Marjory Blood. I am a member of AARP's National Legislative Council and of the Maine Committee on Aging. I also chair the Advisory Committee for Maine's Long-Term Care Ombudsman Program. On behalf of the more than 25 million members of the American Association of Retired Persons, I want to thank you for this opportunity to state the Association's views on the need to reform our nation's long-term care(LTC) quality assurance policies. Before I begin, however, I would like to express AARP's appreciation for the Subcommittee's interest in addressing the quality of nursing home and home health care, issues of increasingly vital concern to millions of American citizens.

THE QUALITY OF NURSING HOME CARE

In March 1986, the Institute of Medicine (IOM) issued a 415-page report on "Improving the Quality of Care in Nursing Homes," the result of a two year independent study undertaken with the support of Congress. Seven major conclusions arose from the study:

1) Quality of care and quality of life in many nursing homes are not satisfactory.
2) More effective government regulation can substantially improve quality in nursing homes. A stronger Federal role is essential.
3) Specific improvements are needed in the regulatory system.
4) There are opportunities to improve quality of care in nursing homes that are independent of changes in the Medicaid payment policies or bed supply.
5) Regulation is necessary but not sufficient for high quality care.
6) A system to obtain standardized data on residents is essential.
7) The regulatory system should be dynamic and evolutionary in outlook.

AARP supports these conclusions and believes that they provide the basis for taking action this year to improve the quality of care in nursing homes through both the legislative and regulatory processes. Unfortunately, nursing home residents, who are an extremely vulnerable and frail population, continue to receive poor quality care in far too many long term care institutions.

These concerns were reiterated in a May 1986 investigation conducted over two years by the Senate Special Committee on Aging. Committee Chairman John Heinz concluded: "This report establishes that our current systems of inspection and enforcement are incapable of assuring that residents actually receive the high quality care the law demands. Congress must act to effectively strengthen these systems and underscore the rights of patients to appropriate, quality care."

The time has come for Congress and the Administration to address the systemic problems contributing to the quality of care deficiencies that persist in many nursing homes today. We can not rely only upon market forces to influence nursing home behavior. AARP strongly endorses the position papers put together by the Campaign for Quality Care in Nursing Homes. Our comments on nursing home quality will focus on four primary areas of concern: nurses aide training, nurse staffing, enforcement, and equal access to quality care. We will then briefly discuss several other issues that need to be addressed.

Nurses Aide Training Standards

Any discussion of nursing home quality must begin with caregivers. In the long term care institution, nurses aides deliver well over 80 percent of the direct hands-on care to residents. Unfortunately, the vast majority of these staff people receive minimum wages and are completely untrained and unskilled. Even more alarming, annual turnover rates in the field are approximately 100 percent. The jobs are characterized by low prestige and little reward. Good training and competency testing of nurses aides is likely to be the area in which federal leadership will have the greatest impact.

Our most recent figures show that 17 states have some form of mandatory nurses aide training programs, with requirements for both classroom and clinical/practicum training. The state of Illinois, for example, is recognized as having an exemplary nurses aide training program. The IOM report strongly recommends that training of nurses aides prior to employment in the long term facility should be federally mandated. AARP recommends that the Secretary of HHS be directed to develop and test training and testing programs for nurses aides, with a minimum of 160 hours of training required, along with developing criteria for approving or disapproving training programs in institutions, including those within nursing homes. Nursing homes should be required to assure that all aides are competent to perform tasks to which they are assigned through regular performance review and regular in-service training. We also recommend that states set up systems to monitor and review aide turnover at nursing homes in order to encourage retention, and that research be conducted at the national level to reduce these extraordinarily high turnover rates.

Nurse Staffing Requirements

Another primary concern is that there simply are not enough nurses in nursing homes. In intermediate care facilities (ICFs), for example, all that is required is that a Licensed Practical Nurse (LPN) be on the day shift seven days per week. Thus, under current federal standards, ICF residents can be left in the care of untrained nurses aides for 16 hours per day, and an unsupervised LPN for the other 8 hours. Without question, this situation creates a potentially dangerous environment for the many frail, dependent, and very old residents that occupy most ICFs.

Staffing requirements for skilled nursing facilities (SNFs) are only somewhat better, as they require a Registered Nurse (RN) to be on duty for only 8 hours per day seven days a week with an LPN on staff 24 hours each day. The ICF/SNF distinction is based on the erroneous assumption that ICF residents are healthier, less vulnerable to life-threatening events, and need less care and supervision than SNF residents. When one considers the much sicker resident population now entering ICFs due to reduced hospital lengths of stay under DRGs, SNF bed shortages, and the fact that the ICF/SNF distinction varies tremendously from state to state (e.g. 94 percent ICFs in Louisianna, 98 percent SNFs in Florida), it becomes even more clear that the ICF staffing requirements must be raised at the very least to the level of the current SNF requirements.

AARP's strong preference, however, would be to require both ICFs and SNFs to have 24 hour, seven day a week RNs on staff. There are important differences in education and training between RNs and LPNs. LPNs, who typically receive at least 2 fewer years of education than RNs, do not have sufficient management, diagnostic, or assessment skills to monitor fluctuating physical conditions or treat the sudden onset of emergency medical situations. We also reject the assumption that care needs inevitably diminish during evening and night hours. The Veterans' Administration provides a model for nurse staffing requirements in its 117 long-term care facilities, which require RNs in charge of each ward, on each shift.

In calling for 24 hour RN staffing in all nursing homes, we are sensitive to the fact that serious shortages of these skilled professionals exist in many areas. AARP, therefore, supports a waiver from the nurse staffing requirement for those homes who are unable to hire an RN despite making a good faith effort to attain their services by offering a competitive wage and benefit package. We hope that both Congress and the Administration will undertake efforts to address these critical shortages, and we pledge our assistance in supporting such endeavors.

Enforcement Issues

Another pressing problem is the insufficient range of both federal and state sanctions available to assure compliance with standards of care. Unless appropriate enforcement mechanisms are available and used effectively, we run the risk of having chronically out of compliance providers continue to operate under public programs without strong incentives to improve quality. Even if every quality assurance recommendation in the IOM report became law, they would be meaningless unless they could be enforced. Too often in the past, deficiencies have been ignored by federal and state authorities because their only recourse was termination from the program and no beds were available for patients who would need to be transferred. Between 1981 and 1984, for example, only 156 out of more than 13,000 nursing homes had their certification terminated. Moreover, large numbers of substandard homes temporarily correct their deficiencies under a plan of correction and quickly lapse into noncompliance until the next survey is conducted. As the IOM committee stated: "Inadequate enforcement is a major problem."

Probably the two most effective sanctions that all states should be required to have in place are civil or administrative fines and court appointed receivers. Currently, 31 states have authority to impose civil or administrative fines and approximately 4 out of 5 IOM survey respondents claim they are an effective intermediate sanction. When state officials were asked during the IOM study why certain sanctions were effective, the two most frequent responses were "affect income of provider" and "quick implementation". In response to a question concerning the obstacles to effective use of sanctions, the most commonly cited obstacle was delays. It is generally accepted that civil fines are among the most effective of the intermediate sanctions because they affect the income of a provider, can be swiftly enforced, unencumbered by lengthy litigation delays, and can be sensitive to the severity of the particular violation and the history of the facility. By raising the price for repeated violations or more serious deficiencies, civil fines can increase pressure on the facility to make fundamental financial or management changes. Civil fines are also the most logical remedy for dealing with element level deficiencies.

Court-appointed receivers can also be a very effective enforcement mechanism. 25 states currently have this remedy available and 5 out of 6 survey respondents believe them to be effective. Receivership is particularly important for use as a threat to facilities that have failed to respond to other sanctions and as a method for providing for the safe transfer of residents from a facility that is closing. Receivership enables the state to force a poor quality facility to upgrade its operations dramatically. In those instances where owners threaten to "take the money and run" rather than comply with state and federal standards, receivership permits gradual relocation of residents, at the owner's expense, in order not to jeopardize residents' health, safety and welfare.

Other enforcement mechanisims which should be put in place in states and nationally include bans on new admissions, appointments of monitors, targeted plans of correction, and private rights of action for Medicare and Medicaid beneficiaries. Admissions freezes are an important tool for dealing with facilities chronically out of compliance because they directly affect provider revenues and can take effect quickly pending appeal. 31 states currently have the authority to suspend all new admissions. 18 states may appoint monitors, who remain in the facility after the survey has been conducted in order to observe first-hand corrective actions and compliance status on a continuing basis. Targeted plans of correction allows enforcement authorities to specifically articulate what must be done to come in compliance, such as hiring additional nursing staff. Finally, a beneficiary private right of action could be an extremely effective remedy for use by those individuals who are most knowledgeable about conditions within the nursing home and who are most likely to suffer personal injury as a result of substandard care. We realize that states may come up with other flexible enforcement mechanisims that would serve the purpose of those discussed above.

It is also important that the federal government monitor state agency activity in the enforcement area through the use of look behind and validation surveys, and other monitoring mechanisms. Too often, states that have a sufficient range of sanctions available fail to use them effectively. Federal and state actions must be closely coordinated and federal financial participation should not be withdrawn when states are in the process of taking action to return the facility to compliance.

Equal Access to Quality Care

AARP is extremely concerned that Medicaid beneficiaries do not have equal access to quality care in the nursing home setting. The strong provider preference for private pay residents is an undisputed fact. In some states, particularly in the southeast, this may be due in part to low Medicaid reimbursement rates. There is consensus between providers and consumers that facilities should not discriminate against Medicaid recipients in their transfer or discharge practices. There is much less consensus, however, in the areas of services and admissions.

AARP believes that facilities should not be to permitted to differentiate between Medicaid and private pay residents with regard to the quality or effectiveness of Medicaid covered items and services. Residents should be free to pay, however, for additional services beyond those required under the Medicaid program.

With regard to discrimination in admissions on the basis of source or amount of payment, AARP would ideally like to see all such discriminatory practices abolished. Since this does not seem to be feasible at the present time, we support an interim compromise which would prohibit discrimination in admissions unless the proportion of Medicaid residents in the facility is equal to or greater than the average Medicaid nursing home census in the state. Similar prohibitions seem to be working well in New Jersey and Ohio, while New York state has recently proposed a similar plan. We believe that such a requirement should be strictly enforced, together with prohibiting certain admission practices such as "responsible party" signatories or accepting gifts or other consideration as a condition of admission or continued stay.

AARP also strongly urges the Congress to pass legislation this year to increase Medicaid nursing home residents' personal needs allowance (PNA) by $10 per resident per month, from $25 to $35, indexed by a cost of living adjustment. The PNA covers a wide range of expenses not paid for under Medicaid, such as clothing, newspapers and phone calls, and has not been increased since it was first authorized in 1972. The change would restore a small amount of dignity, independence and purchasing power to these indigent nursing home residents, most of whom where forced to give up all their income and assets, and to impoverish themselves as a result of the spend-down process.

We also support legislation to: require nursing homes to have an RN conduct a resident assessment which includes a federal minimum data set of core elements and common definitions; assure that all residents have access to appropriate social services and mental health services; require states to specify what their Medicaid program covers and how their reimbursement rates are determined; require providers to disclose all cost and charge information; encourage states to implement reimbursement systems which reward high quality and are sensitive to individual residents' care needs; raise nursing home regulations on residents' rights to the level of a condition of participation; phase-out the SNF/ICF level of care distinction as payment systems based on resident care needs are phased-in; improve surveyor training and attempt to minimize subjectivity in making compliance determinations; and, improve access to facilities and relevant documents for ombudsmen. These issues are addressed in greater detail in the position papers strongly supported by AARP that were developed by the Campaign for Quality Care in Nursing Homes.

THE QUALITY OF HOME HEALTH CARE

Home health care represents a vital and increasingly important component of medical services. It allows persons to receive, at home, care that enhances the quality of their lives and, in some cases, helps avoid institutionalization or hospitalization. Home care can be be primarily medical in nature or it can consist of services aimed at enabling the individual to live independently in the community.

The home care field is growing and changing rapidly; between 1981 and 1985, there was a 74 percent increase in the number of Medicare certified home health agencies. A recent study by our Public Policy Institute found, however, that consumers are having an increasingly difficult time gaining access to home care benefits because regulations for eligibility have been more stringently applied by Medicare, both through increased denials of claims and reinterpretations of regulations concerning intermittency and homebound status. Denials of claims increased 133 percent from the last quarter to 1983 to the first quarter of 1986. Moreover, there is great variability across the fiscal intermediaries in these denial rates.

For those who are lucky enough to receive home health care, quality concerns immediately arise. In contrast to its efforts to constrain coverage, Medicare does little to assure quality or to regulate home care providers. The mechanisms that the Health Care Financing Administration use are weak, and since 1981, only 23 of about 6,000 current providers have been involuntarily dropped from participation in Medicare. Other evidence suggests that in at least one region, numerous deficiencies have been found. For example, in a state with its own quality monitoring system, 40 percent of the 60 providers were found to be deficient in "coordination of patient services" and 70 percent were deficient in "conformance with physicians' orders."

AARP is particularly concerned about quality assurance in the home care setting because of the vulnerability of the frail recipients of services from strangers in a location beyond the easy reach of public scrutiny. Additionally, practically no public information is available today on the quality of home care. We currently have no consistent, comprehensive regulatory scheme to measure or ensure quality of care. Licensing and certification standards also vary greatly among the states. There are few avenues of recourse open to persons inappropriately denied care or given substandard care. Indeed, in some instances there may not be a standard of care. Caveat Emptor is an irresponsible standard for our most vulnerable citizens. Consumer protection must be built into our home health care programs as soon as possible.

Two areas that must be addressed promptly are similar to those already discussed above with nursing homes; namely, training of aides and the availability of intermediate sanctions. There are many parallels in these areas between the nursing home and home care fields. The two industries compete in virtually the same labor pool (along with fast food chains) in attempting to hire nurses' aides or home health aides. Similar problems exist in that home health aides, as well as homemakers, are generally poorly trained, poorly paid, and work in an environment that is often undesirable. It is essential that these workers be properly trained prior to rendering services, that standards be established to promote competency, and that agencies conduct background checks prior to allowing them to enter clients' homes.

With regard to current enforcement mechanisms, again, authorities now only can choose between doing nothing or dropping agencies from participation in the program. A greater range of sanction options needs to be available, including civil fines, receivership, and denials of payment for new admissions. Federal regulators became authorized to use this last sanction against nursing home providers in July, 1986, but the rule, for some unknown reason, did not apply to home health agencies. AARP also supports stipulating timetables for correcting deficiencies, with a graduated series of more severe sanctions being imposed for continuing noncompliance.

Other areas that have already been addressed in the nursing home field but still need to be addressed for home health include reforms in the Medicare survey and certification process and the establishment of a consumer grievance mechanism.

Medicare Survey and Certification

The current process by which a provider becomes certified to receive Medicare payments for rendering home health services has little or nothing to do with the quality of the care delivered.

Surveys are conducted only about once every two years, for the most part to ensure only that services that have been paid for have actually been delivered. Verification that the Medicare Conditions of Participation are met is based on a check of "paper compliance" and fails to measure quality in any significant way. Clients are rarely interviewed to determine the kind of care actually provided. The nursing home experience is instructive, where a patient-based, outcome oriented survey utilizing resident interview information was implemented last year. A similar process must be put into effect for home health agencies, and unannounced surveys need to be conducted more frequently, according to compliance status. We are pleased to see that HCFA has recently awarded a grant for the development of such an instrument. We urge that new assessment and survey instruments be put in place within the next 18 months.

We also urge that a new section be added to the Medicare Conditions of Participation covering patients' rights. These should include participation in the plan of care when possible, and the right to receive information on service coverage and charges, and on caregivers who will be coming into the home.

Finally, it is important that consumers have information available to them regarding the compliance status of agencies so that they will be able to make an informed choice when selecting a home health agency. Since the initial investment necessary to open up a home care agency is relatively small, consumers are in jeopardy of not knowing which agencies are reputable and which are "fly by night" operations. A directory should be made available to the public specifying which agencies are Medicare certified, whether they have been cited for any significant deficiencies relating to client care, and whether sanctions have been imposed on the agency. Such a directory would be a valuable consumer protection tool.

Consumer Grievance Mechanisms

It is frightening to know that recipients of home care services who have been abused or been given substandard care presently have virtually no place to turn other than to formal law enforcement officials. The lack of any organized program to receive and investigate consumer complaints is largely responsible for our almost complete lack of knowledge about what is occurring behind those closed doors.

To protect consumers, all home care providers should have written client grievance procedures, and states or local communities should be required to implement an advocacy program with enforcement authority to receive and investigate consumer complaints. The mechanism could serve a variety of functions: ensuring understanding and implementation of legal rights, encouraging self-advocacy and providing assistance and support until problems are resolved, providing information and referral services regarding home care issues, providing training and continuing education for volunteer advocates, and protecting the privacy and confidentiality of clients and their families. Access to the program should be supplied through the maintenance of a toll-free hotline. Investigators must also have access to consumer medical records and survey reports. Of course, precautions must be taken to ensure that the voicing of grievances by clients does not result in reprisals of any kind.

Finally, we hope that this Committee is sensitive to the fact that approximately 30 percent of all home health agencies do not participate in the Medicare program. Public funding, when available, for these typically non-medically oriented agencies is fragmented under Medicaid, the Social Services Block Grant, and the Older Americans Act. Although it may not be within the jurisdiction of this Committee, Congress must take a close look at the quality of care delivered by these almost totally unregulated agencies. We should begin by requiring all states to license home care providers before delivering support, or "home help" services, such as housekeeping or meals on wheels. 34 states currently require some form of licensing, but most simply cite the Medicare home health regulations and fail to address the non-health component of home care. These very limited oversight mechanisms are generally uncoordinated and overlapping and result in serious fragmentation in accountability. Federal leadership and guidance in this area would be extremely helpful.

CONCLUSION

In conclusion, AARP is grateful that this Committee has chosen to take a look at long term care quality issues. We are particularly pleased about the legislation introduced by Senators Mitchell and Bradley that address almost all of the nursing home and home health quality concerns we have expressed here. We enthusiastically support both of these bills, and offer our resources and assistance to enact these reforms into law this year.

Senator **MITCHELL**. Ms. Mootz.

STATEMENT OF ANN MOOTZ, FORMER DIRECTOR, HOME AIDE SERVICE AND UNITED HOME CARE, CINCINNATI, OH; ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE

Ms. **MOOTZ**. Mr. Chairman, we in the home care field are very pleased to participate today in this focus on quality issues in home care. As you know, there has been a growing demand in the last five years for home care related to some of the lifting of Medicare requirements, to the great growth in the older population, and to DRGs.

At the same time this is taking place, Medicare coverage has been reduced by many administrative actions, such as restrictions interpretations of "intermittent care" and "home bound" definitions. These have been major problems. Fortunately, they are well covered in your new Medicare Home Health Services Improvement Act. And we would hope that passage of this legislation would solve those problems.

This kind of diminishing ability of Medicare to meet people's needs has led to a lot more dependence on some of the other programs, as I think Ms. Blood was referring to, for instance, the Social Service Block Grant Home Care Programs through Title 3 of the Older Americans Act. And these programs have no standards written in them many times. They are fragmented. They have very confusing reimbursement and coverage regulations. So, the use of these programs with the growing demand has led to, I think, some real quality care programs in the home care field that haven't been there until recently.

In our agency, for instance, where we utilize all these programs and any other ones I could find, taking care of 2,500 people a week, we still had always 300 to 400 people on our waiting list, many in their 80s and very disabled who didn't qualify for any of the programs because of the many limitations in them.

In the current Federal programs, Medicare of course has the Medicare conditions of participation. The major weakness we see in the Medicaid Standards is that they do not specify a method for meeting training and the supervision requirements for home health aides.

The Medicare Home Health Services Improvement Act would also take care of that; but the other Federal programs do not have any conditions of participation, no Federally mandated standards at all. They rely totally on State and local government standards, and most of these are minimal or absent.

Particular problems that we have been concerned about are in the use of paraprofessionals. There is a lack of consistent basic standards for them. The training is not specified, and we do not even know what to call them. The home health aide in the Medicare Program is essentially doing the same things as the homemaker in the Social Service Block Grant Programs, the same tasks as the personal care aide or the attendant in the mental health or mental retardation programs. And these different titles are very confusing to those who monitor them, and I think one of the things that has handicapped development of some of the paraprofessional standards. In Europe, they get around this by calling them all Home Helps.

We are particularly concerned about the training and the supervision requirements for these paraprofessionals. To deal with that problem, the National HomeCaring Council has promulgated national standards for homemaker-home health aide services and has administered an accreditation and approval program since 1962. The National League of Nursing and the Joint Commission on Accreditation of Hospitals also each accredit home care programs. But these are voluntary programs, and only a minority of home care agencies have participated.

One program has 135 agencies, for instance, and the other 110, and this, I think, is out of approximately 6,000 home care agencies. So, it is a very small amount. The National HomeCaring Council has also developed under contract with the United States Public Health Service—in 1978—a model curriculum for training, and that could be used in Federal legislation.

In June of 1985, the Rensselaer County (New York) Long-Term Care Coordinating Committee addressed the problem of why we don't have an adequate number of homemaker-home health aides. Of course, it is because it is low paying, very demanding job, and cannot then attract some of our best people.

We are therefore proposing to improve these conditions we recommend: that there be consistent job titles for paraprofessionals, that there be basic training requirements on which we could build additional training for specialized needs, and that there be basic common supervision and monitoring requirements with States required to fix the locus for these, and that basic benefits, wage policies, and safeguards be provided for the paraprofessionals.

Until we have Federally mandated standards, we are going to have to rely on the State licensure programs which have been very, very inadequate to control quality in home care to this point.

Senator MITCHELL. There will be some questions submitted for you in writing. I have been asked by Senator Bradley to ask one, so I would like to read that now to you and then have further questions later on.

We want HCFA to develop patient outcome data for use in assessing the quality of home care. Do you think, in an effort to direct HCFA, that Federal law should specify the specific type of outcome data that we seek? In other words, should Federal law be very prescriptive in this area? If so, do you have any suggestions on how to accomplish this?

You can either respond now orally, if you would like, or you can submit a written statement later, or both.

Ms. Mootz?

Ms. MOOTZ. I would like to comment orally now, and I am sure that the National Association for Home Care may wish to write you something later.

From my experience in dealing with HCFA, which I was a director of a home health agency for 20 years, I would say that it is very important that the law be very specific about what should be done because I certainly would not trust the administrative interpretations of the intent of that law.

Senator **Mitchell**. Ms. Blood, do you care to respond, or would you like to do so later in writing?

Ms. **Blood**. I would like to make a short response orally.

Senator **Mitchell**. All right.

Ms. **Blood**. And that is that the outcome survey must have a base reference in order to know from where you started and where you have arrived with a patient. And the outcomes, I think, should be specified in the law, and I think perhaps it could include such things as client and family satisfaction, the ability to continue or have improving self-care, the training and education that has gone on in providing care for that person, and also to look at how often the person has had to return to the doctor or the emergency room or the hospital or the nursing home.

I think those are all important considerations.

Senator **Mitchell**. Thank you very much, both Ms. Blood and Ms. Mootz.

[The prepared written statement of Ms. Mootz and answers to questions from Senator Mitchell & Bradley follows:]

ANN MOOTZ

FORMER DIRECTOR OF HOME AIDE SERVICE AND UNITED HOME CARE

SENATE FINANCE COMMITTEE SUBCOMMITTEE ON HEALTH HEARING ON QUALITY OF CARE, April 28, 1987

Mr. Chairman and Committee Members:

I am Ann Mootz, here representing the National Association for Home Care (NAHC). For the past 20 years, I was Director of Home Aide Service and United Home Care in Cincinnati until retiring this past January. I sat on the Board of Directors of the National Homecaring Council for 15 years and chaired their Accreditation Committee for 5 years. I have served as a member of the NAHC Quality Assurance Committee and currently serve on the National Homecaring Council Advisory Board.

NAHC is the largest professional organization representing the interests of home health agencies, homemaker-home health aide organizations and hospices with approximately 5,000 members. NAHC is committed to assuring the availability of humane, cost-effective, high quality home care services to all who require them.

We in the home care field are pleased to participate in this effort to focus on the issue of quality of services and problems with the delivery of home care. The issue of quality is critical to what we do and what we are all about. Home care services are provided behind closed doors in private homes, to millions of people who by definition are the vulnerable members of our society due to their inability to care for themselves. The care is rendered in a setting which is not subject to public scrutiny. The very nature of the services places unique responsibilities on providers of care.

OVERVIEW OF QUALITY OF HOME CARE

We are proud of a record of outstanding service to the ill, elderly, and disabled in this country. Home care in the U.S. traces its origins back to 1885, with Visiting Nurse Associations across the country springing up to provide health care to an influx of immigrants. Home health was accepted as part of the Medicare program in 1965, and became more available to millions of elderly and disabled Americans. In its 101 year history, home care has enjoyed ever growing support, and a largely unblemished reputation. The vast majority of patients have been very pleased with the services they received, and the quality of those services. In the entire history of Medicare and Medicaid since their enactment in 1965, there have been less then a dozen convictions of home care providers for fraud. This is too many, but is an enviable record compared to the literally thousands of other providers in various categories of health care who have been convicted.

Home care has been free of quality problems for many reasons, one of which is that the field was comparatively small. Now, however, there is a growing appreciation and demand for home care. The rapid growth of the industry can be traced to an easing of eligibility requirements under the Medicare law and to the impact of hospital prospective payment system as well as to demographic factors.

This increased demand has come at a time when access to the home health benefit under Medicare is being limited.

ADMINISTRATIVE REDUCTION IN THE MEDICARE HOME HEALTH BENEFIT

Recent policies of the Health Care Financing Administration (HCFA) "to restrain beneficiary protections, combined with vague and confusing guidelines for providers, result in reduced access to home health care for Older Americans", according to a July, 1986 report by the Senate Special Committee on Aging.

The report noted that although hospital discharges to home health have increased 37 percent since prospective payment for hospitals was implemented, the growth in home health services since then has slowed. A 1987 General Accounting Office survey of hospital discharge planners revealed that 86 percent "reported problems with home health care placements" for Medicare beneficiaries. 52 percent of those surveyed cited "Medicare program rules and regulations" as "the most important barrier" to these placements. It is no coincidence that HCFA's own statistics show that the percentage of home health claims denied under the Medicare program rose from 1.2 percent in 1983 to over 6.0 percent in 1986. And this figure does not include the many patients who are effectively denied Medicare coverage because home health agencies, incapable of assuming the costs of non-covered care, avoid Medicare claims submissions.

The present HCFA guidelines allow for daily visits for a two to three week period, and thereafter, visits may be continued upon a showing of exceptional circumstances. This level of services is often inadequate to care for more acutely ill patients who are being discharged from hospitals.

In addition, definitions of what constitutes "intermittent care" vary tremendously, depending on the fiscal intermediary's (FI's) interpretation. As a result, Medicare, which is supposed to be a national program, is not enforced uniformly, and what is covered for one beneficiary in one state is not covered in other state.

A related practice, known as "selective billing," has served to further restrict home care coverage for Medicare beneficiaries. If patients are receiving coverage under Medicare, in many cases they cannot receive additional coverage from Medicaid or any other payment source (private insurance, self-pay, Social Services Block Grant, etc.). For example, if patient A is receiving 3 hours of nursing care and 2 hours of aide care for 3 days a week paid for by Medicare, and he or his family wants an additional 2 hours of nursing care on the other 2 days which will be paid by concerned relatives, Medicare intermediaries will deny the Medicare coverage, claiming that the patient is exceeding the "intermittent care" requirement. This either will result in no care, limited care, or the forced institutionalization of an individual whose family cannot sustain him at home if Medicare refuses to pay its fair share.

The Medicare homebound guideline allows the patient to be considered homebound if he has infrequent or short duration absences from the home primarily for medical treatment or "occasional non-medical purposes" (e.g., trip to barber, a drive, walk around the block).

The current definition in the guidelines is interpreted in an inconsistent and varying manner by fiscal intermediaries. This is especially so in cases where beneficiaries are leaving their homes to go out for periodic adult day care, outpatient kidney dialysis, chemotherapy and other similar treatment. Even though the current guideline allows beneficiaries to go out for medical reasons, some FIs severely limit frequency and others do not honor the medical reason exception at all. In situations where individuals leave their homes for either medical or non-medical reasons, individual FIs have their own interpretations as to what they consider frequent or infrequent, or whether they consider the patient homebound if he or she leaves home with the aid of an ambulance or other extraordinary assistance.

This ratcheting down of the Medicare home health benefit has increased the demand for services under Social Services Block Grant and Title III (the Older Americans Act). These programs are plagued with fragmentation of services eligibility, coverage, reimbursement, and standards, which, when combined with the burgeoning demand, fosters the potential for decreased quality in home care services.

The home care community has no more vital interest at the present time than to ensure the high quality of service. That is why I am delighted to be here with you today, to discuss with you a few areas in which problems occur and will escalate. I also plan to make recommendations for improvements in those areas.

CURRENT STATUS OF FEDERAL PROGRAMS

The most important uniform quality controls for home health agencies are the federal "Medicare Conditions of Participation". These standards, which apply to some 5,000 home health agencies certified for participation in the Medicare program, set forth basic standards for organization, services, administration, professional personnel, acceptance of patients, plans of treatment, medical supervision, skilled nursing services, therapy services, medical social services, home health aide services, clinical records, and evaluation. These standards are the minimum with which Medicare-certified home health agencies must comply; several states require higher standards in some areas. The Medicare standards are generally appropriate and reasonable, but they do not specify a particular method for meeting training and supervision requirements for home health aides.

The other federally financed programs (Medicaid, Social Services Block Grants to states, and the Older Americans Act), do not have conditions of participation which contain uniform standards for home care services. Instead, the programs utilize standards devised by various state or local governments, some of which are extremely minimal or absent. Others have no standards, but simply rely on the lowest unit price bidder to provide these services. Others have written standards, but have inadequate staff to monitor and enforce them.

PROBLEM AREAS IN PARAPROFESSIONAL SERVICES

As you can imagine, a fundamental problem in these federal programs is a lack of consistent basic standards for paraprofessionals. The home health aide of the Medicare program is essentially doing the same tasks as the homemaker of the Social Services Block Grant program, the same tasks as the personal care aide of the Medicaid program, and the same tasks as the home aide in some programs for the aging, those with mental illness, or people who are developmentally disabled. The various titles used to designate the home care worker reflect various funding sources, not actual tasks. The paraprofessional function is the same: to provide appropriate supportive services to persons in their homes under the proper professional supervision and in accordance with a plan of care. But the programs lack minimum mandatory supervision and training requirements for homemaker-home health aides.

We are particularly concerned about training and supervision requirements for homemaker-home health aides and other paraprofessionals. The issue of standards for paraprofessionals in home care is not new. To deal with the problem, the National Homecaring Council has promulgated national standards for homemaker-home health aide services, and has administered an accreditation and approval program based on those standards since 1962. (Accreditation requires a site visit, while approval requires only a self-study and other written materials). The standards cover agency structure, staffing, training, supervision, service, and community relations. The National League for Nursing and the Joint Commission on Accreditation of Hospitals also accredit home health programs provided through some community agencies and hospitals. Such accreditation or approval is entirely voluntary, however and only a minority of home care agencies in the country are accredited or approved.

The National Homecaring Council also developed, under contract to the U.S. Public Health Service, a model curriculum and teaching guide for the instruction of the homemaker-home health aide in 1978. This curriculum has been updated and is now in its third printing (1984). This 60-hour training program is referred to in the Federal home health agency expansion and training grants administered by the Public Health Service. Thus, certain basic standards and curricula already exist, but are simply not used in many federal and state programs.

It is ironic that standards and training curricula are established for individuals who are professionally trained and licensed, such as physicians and nurses, while there are no uniform standards for paraprofessionals, often have less formal education.

The individuals providing these paraprofessional services are, in large majority, sincere, dedicated and hardworking people who are underpaid in relation to the value of the work they do. Few have paid vacations or holidays, and even fewer have paid health insurance coverage. We have not given adequate attention or recognition to the persons who provide this vital service; in fact, in many respects we have exploited them. We have sown seeds for a potential scandal. We have ignored the escalating human needs of paraprofessionals while we have continued to delegate more care to them, and to place more demands on them.

In June, 1985, the Rensselaer County (New York) long-term care coordinating committee, a group composed of representatives of home care providers, hospitals, nursing homes, health planners, and county government issued a report which recommended increased use of home health aides and personal care aides services, based on enhancement of the labor pool. The report noted that "homemaker/personal care has been a difficult service to staff and maintain with a stable personnel pool over time. Within the last five years, this labor pool appears to have diminished even more. In light of demographic trends which indicate a growing need for this type of service, it is essential that the pool of workers be expanded and stabilized."

"Clearly, marketing is important in tackling this task. There are several reasons why personal care is not a highly desirable career path. Wages are low, the work environment variable, and often undesirable. Work hours are not generally\guaranteed. Transportation from case to case is generally the worker's responsibility. Consumers are often unclear about the worker's role and responsibilities. Clients often demand inappropriate care. The collegial atmosphere in a contained work unit is absent, as caregiving is outstationed, resulting in lack of regular peer support. Public recognition of the value of such a position is non-existent. Homemaker/personal care service is a low status, low prestige, low ceiling occupation."

Keeping this in mind, why would anyone want to perform this function?" (Enhancing Aide Service in the Home: Recommendations for Action, report of the Long Term Care Coordinating Committee, Rensselaer County, New York, 1985).

The report then went on to call for expansion of the personnel base by vigorous marketing and recruitment efforts, structured career paths, basic benefit packages, in-service training, and other actions which not only would attract and retain workers, but also give them a feeling of self worth and adequate pay for the work performed.

Clearly, much needs to be done to attract and retain paraprofessionals, but the quality of paraprofessionals could be enhanced by more adequate reimbursement for their services.

PROPOSED STANDARDS FOR PARAPROFESSIONAL SERVICES

In short, to improve the home care services offered in federally-funded programs, uniform conditions of participation should be developed and implemented, and paraprofessional salaries and fringe benefits should be increased.

The conditions of participation I propose would apply to all federally reimbursed programs providing paraprofessional home care services (Medicare, Medicaid, Social Services Block Grant, Older Americans Act, etc.). Under the conditions, these federal programs would be required to have:

1. Consistent job titles,
2. Basic training requirements, on which could be built additional training needed for specific programs or client groups,
3. Basic common supervision and monitoring requirements with states required to fix the locus of these and accept responsibility for them, and
4. Basic benefits, wage policies, and safeguards for the persons who provide this vitally important service.

In addition, reimbursement for services in the home should be allowed to increase in order to more adequately compensate for the value of the services these paraprofessionals are providing.

STATE LICENSURE AND REGULATION OF HOME CARE

Until there are Federally-mandated standards, state licensure programs are our only means for ensuring standards. Present state licensure laws, however, present a crazy quilt of who is regulated, who is protected, and from what.

Currently, 36 states have some form of licensure laws covering home health agencies. There is no uniformity among these laws (and their implementing regulations). There is also no model licensure law (or regulations) to look to for guidance. Thus, in the states without a licensure law (and in many states with a licensure law) there is inadequate state regulation to ensure that home care agencies are fiscally stable and staffed and organized so as to ensure quality care. Certificate of Need (CON) laws do not provide a regulatory solution to assure quality and fiscal stability in lieu of licensure.

There should be a model law to provide states with guidance in developing a home care agency licensure law and regulations, and to ensure or enforce standards for persons providing homemaker-home health aide services. We would be happy to work with Congress to develop model licensure provisions to fill this gap.

USE OF INDIVIDUALS AS PROVIDERS

There is a serious problem when states subcontract directly with individuals to provide nursing and homemaker-home health aide services instead of obtaining these services through an agency. The approach of using individuals as providers has created problems where there has been insufficient training or supervision of the caregivers, with the result that the quality of care is often poor. Worse than that, there have been numerous examples of outright abuse of clients by caregivers. A recent incident in California illustrates how serious such abuse can be. There, an independent contractor aide was arrested and charged with arson, attempted murder, and fraud after she allegedly attempted to murder her client to cover up stealing nearly $5,000 from him during the year she had cared for him. We want to avert such dreadful incidents in the future.

The primary impediment to the states' use of independent providers is that the Internal Revenue Service (IRS) views these invididual providers (and properly so) as employees of the state. This means that under present law, the states and counties are required to pay FICA, unemployment and worker's compensation as well as withhold federal income tax on behalf of these individuals. In some instances, however, these payments on behalf of the employees are not made unless a challenge is brought against the state.

In addition, some Area Agencies on Aging (AAAs) and the states through Medicaid or the Social Services Block Grant program are currently hiring case managers who, while they are not providing direct patient care, are brokering the provision of home care and supportive services. The problem is that some case managers are hiring or contracting with individuals directly to provide services instead of dealing through agencies meeting recognized standards in the home care field, such as those established by Medicare certification. The National Homecaring Council, the National League for Nursing, or the Joint Commission on Accreditation of Hospitals. In some cases, the result has been a lack of training; poor, if any, supervision; and some examples of poor care and abuse. Again in these cases the agency brokering or assigning the worker should be responsible for adequate training and supervision, as well as for employee benefits.

A related problem is the method by which some Area Agencies on Aging and the states contract out for home care services under the Social Services Block Grant and Title III. Contracts are placed out for bid and the lowest cost provider is chosen. This method may be appropriate for bridges and roads, but is unsuitable and dangerous for home care and supportive services. Accredited and certified agencies cannot complete on a straight cost basis. The result is that under-qualified and under- supervised individuals are being chosen to render care under these titles. Contracts under block grants and Title III should be based not only on cost but also on required levels of training and supervision which should be specified in the contract.

SUMMARY

In conclusion, while we are proud of the services we provide to ill, disabled, and elderly Americans to maintain them in their homes, we would like to suggest some ways in which the quality of care could be improved. We recommend:

- Uniform conditions of participation or uniform training and supervision standards based on level of care need for all federally funded programs utilizing paraprofessionals; or training requirements based on the model curriculum should be included in OAA and Social Services Block Grant legislation;

- Increased reimbursement for paraprofessional services;

Common definitions which would make these programs easier for the public to understand and for the government to monitor;

- Development of a model law and regulations for home care licensure; and
- Prohibition of independent employment of paraprofessionals using federal funds.

In addition, Congress should enact S.1076, the Medicare Home Health Services Improvement Act of 1987, which would clarify the Medicare home health benefit so that beneficiaries receive the services they need. This bill, introduced by Senators Bradley and Mitchell, and co-sponsored by Senators Heinz, Rockefeller, Daschle, Matsunaga, Moynihan, Pryor, Durenberger, Riegle and Baucus of this Committee, would:

- Clarify the definition of intermittent care to include one or more visits per day on a daily basis for up to 60 days and thereafter under exceptional circumstances. Daily care whould be clarified to mean seven days per week;
- Codify the current homebound guideline and clarify that an individual need not be totally dependent and bedridden to be considered homebound.
- Improve the quality of care in a number of ways, including creating standards for training of paraprofessionals and a patient bill of rights for home care consumers.

Thank you for the opportunity to be here today to discuss these important issues wtih you. I will be happy to respond to any questions you may have.

QUESTIONS FOR ANN MOOTZ FROM SENATOR MITCHELL

1. One of the recommendations you make for assuring high quality home health care is to increase the compensation paid to home health professionals. Do you think that the Medicare and Medicaid reimbursement rules for home health care are part of the problem of low wages, or does the Medicare wage index (for example) allow wage increases to be taken into account in determining reimbursement, if the home health agencies paid higher wages?

Answer: By and large, Medicare covers only a small percentage of home health care paraprofessional services. Recent Federal Medicare policies which have reduced the upper limits of payments to providers have maintained low wages for home health aides. However, homemaker-home health aides are primarily reimbursed under Medicaid and other state and Federal programs, and it is under the Medicaid, Title III of the Older Americans Act and the Social Services Block Grant programs that wage problems are most intense. Problems exist under those programs because there is no requirement or incentive to pay more than the minimum wage, and other employers can offer more attractive wages and working conditions. In addition, since home health services are labor-intensive, the major way to cut costs to be competitive is through wages. That fact is particularly important in competitive bidding for home health contracts. Competitive bidding does not have to adversely affect quality of services, but competitive bidding without quality controls may allow some bidders to undercut the market, providing incentices to pay workers lower wages.

1a. With demand for home health services increasing dramatically, why are wages not increasing sufficiently to attract and retain adequate numbers of home health paraprofessionals?

Answer: Although the demand for home health services is increasing, the funding has not increased proportionately. Although the total dollars spent by Medicare for home health services has been increasing, HCFA has reduced the upper limit of what it will pay to providers each year for the past two years. Many state Medicaid programs have also reduced funding for home health services, both in terms of coverage and reimbursement to providers.

2. You recommend a number of Federal steps to standardize training and other quality assurance measures. How do States react to your proposals to have the Federal Government in effect preempt State regulatory authority in this area?

Answer: Although some states may react negatively to the idea of Federal involvement in quality asurance measures, such involvement is not new, since the Federal government is already involved in monitoring services provided under Medicaid. It is NAHC's position that the Federal government should accept appropriate fiduciary responsibility for quality services for programs that it is funding, either in whole or in part.

2a. Given that most home health agencies have not adopted the voluntary training and supervision requirements for paraprofessionals that you describe in your testimony, do you think that they would support Federal standards?

Answer: Costs of compliance with Federal standards should be recoverable through the appropriate reimbursement systems. Minimizing adverse financial impact of improved standards on providers would enable them to be more supportive of such standards.

QUESTIONS FOR ANN MOOTZ FROM SENTOR BILL BRADLEY

1. We want HCFA to develop patient outcome data for use in assessing the quality of home care. Do you think, in an effort to direct HCFA, that Federal law should specify the specific types of outcome data that we seek? In other words, should federal law be very prescriptive in this area? If so, do you have any suggestions on how to accomplish this?

   Answer: Congress should require a study on the use of patient outcome data in assessing the quality of home care, that is, a study of appropriate indicators for measuring quality of care. Once appropriate indicators are determined, Congress should require HCFA to implement patient outcome standards within certain generalized parameters.

2. Currently, the only sanction against a home care agency that is providing poor quality of care is termination from the Medicare program. Shouldn't we establish a series of intermediate sanctions--fines, penalties, etc.--to penalize poor performance?

   Answer: NAHC supports the use of intermediate sanctions for home health agencies rather than abrupt termination from the Medicaid program. Such sanctions should, however, be proportionate to the violations of the conditions of participation which are related to patient care. Because of numerous stringent interpretations and variations of interpretations under state surveying practices, an agency may be alleged to have gone out of compliance with one or more of the Medicare conditions of participation but pose no immediate, actual and documentable risk or threat to the health or safety of any patient. Such an agency should be treated differently than one where there is evidence of abuse of patients or fraud or other problems which pose a risk to patients.

3. My home care bill requires that State agencies establish, within the context of Medicare, a hot-line and an ombudsman-like unit for investigating home care patient complaints. The Older Americans Act now requires an ombusdman to look into nursing home quality concerns. Should this function for home care be established under Medicare or under the programs within the context of the Older Americans Act?

   Answer: The ombudsman function for home care should cover all Federally-funded home care, and should be established in a unit which does not fund or provide home care services.

4. How important to improving quality is the establishment of standards for home health aide training programs, as required by law since 1981 but never implemented?

Answer: The establishment of standards for home health aide training programs is crucial. With current standards varying from state to state, both consumers and home health agencies are at risk. A model curriculum for the instruction of the homemaker-home health aide was developed in 1978 by the National HomeCaring Council, under contract to the U.S. Public Health Service. This curriculum has been updated and is now in its third printing (1984). Thus, basic standards and curricula exist, but have simply not been adopted by the Medicare program (or other Federal and State programs). The need for Federal training standards is one of the largest unaddressed issues relating to quality of care.

Senator **Mitchell**. All right. Thank you both very much. Your testimony is informative and useful, and we look forward to working with you in this important area. The hearing is concluded.

[Whereupon, at 4:04 p.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

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TESTIMONY OF

EDWIN M. COHN, M.D., FACG
NATIONAL AFFAIRS CHAIRMAN
OF THE
AMERICAN COLLEGE OF GASTROENTEROLOGY

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
UNITED STATES SENATE

CONCERNING

MEDICARE COVERAGE FOR LONG-TERM
HEALTH CARE

APRIL 28, 1987

Annual Postgraduate Course and Scientific Meeting
October 24-28, 1987, Fairmont Hotel, Dallas, Texas

Mr. Chairman and Members of the Subcommittee, the American College of Gastroenterology (ACG) appreciates this opportunity to express our views on Medicare coverage for long-term health care services. We believe that the time for us, as a nation, to address the problem of inadequate health care coverage is long overdue.

Today, millions of elderly Americans are exposed to financial hardship due to a need for long-term health care. Gastroenterologists see these patients on a daily basis. These individuals, most of whom have worked hard all their lives, should not be asked to surrender their life's savings because of their health needs. The American College of Gastroenterology believes that Medicare should provide coverage for long-term health care in order to prevent the financial devastation that American families are enduring solely because one family member has a need for long-term care services.

Furthermore, ACG believes that the current obsession with cost-containment combined with the Medicare prospective payment system has caused a decline in the quality of care being delivered in this country. Large numbers of not-fully-recovered Medicare patients in need of sub-acute medical attention are being released from hospitals into their communities for care. Our nation's health care system is not designed to handle such medical needs. Long-term care providers do not have the resources necessary to "gear up" to meet sub-acute care needs of the discharged Medicare patients. There are simply not enough facilities. This problem is further exacerbated by current federal policy and restrictions that discourage development of new long-term care facilities. Some would respond to that statement by saying that Homecare is more readily available to patients discharged from hospitals after a PPS stay. ACG concurs with this, but also would like to warn that Homecare in many cases is not an adequate substitute for nursing home care, a perception we are afraid that many cost conscious policy makers would like to believe. Allow me to also mention that because of the lack of intermediate sub-acute care facilities available in many areas, some Medicare patients, who are ready for hospital discharge but not well enough for Homecare, are kept at the hospital, at the hospital's expense, additional days while a "precious and few" nursing home bed is secured.

Many physicians find themselves in a similar situation. Most gastrointestinal patients have complex and unique health care needs that require thorough examinations and continuous follow-up. But the Diagnostic Related Groups of the PPS, and Medicare in general, does not allow for this emphasis. Instead, there is a push by Medicare and the Health Care Finance Administration to discourage thorough medical gastrointestinal examinations, GI patient nutrition and diet monitoring, and conscientious patient follow-up. An indication of this may be

HCFA's current efforts to encourage elderly beneficiaries to join with HMO's which have traditionally been geared towards providing care for healthy young people.

Consequently, to improve our already inadequate system of providing medical care for aged individuals, the American College of Gastroenterology recommends that Congress move swiftly and thoughtfully to enact Federal legislation to provide Medicare coverage for long-term health care services.

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to present our views. The American College of Gastroenterology is happy to assist you in any way Members deem appropriate.

AMPRA AMERICAN MEDICAL PEER REVIEW ASSOCIATION
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WRITTEN STATEMENT

For

Committee on Finance

Subcommittee on Health
on
Quality of Long Term Care

April 28, 1987

WRITTEN STATEMENT

AMERICAN MEDICAL PEER REVIEW ASSOCIATION

The American Medical Peer Review Association (AMPRA) wishes to submit this written statement for the public record of the hearing held on April 28, 1987 by the Finance Subcommittee on Health on Quality of Long Term Care. The statement specifically addresses the plans of the Health Care Financing Administration (HCFA) to implement two sections of OBRA which deals with PRO review of post-acute care. Section 9352(b) mandates review of readmissions to the hospital within 31 days of a discharge and includes provisions to review, if indicated, the intervening care which was rendered either in a skilled nursing facility (SNF), hospital outpatient department or by a home health agency (HHA). Furthermore, there is a less clearly defined section (1154(4)(A)) of the Social Security Act which addresses review of care rendered in post-acute settings (irrespective of preceding or subsequent hospital admissions). It is AMPRA's understanding that HCFA plans to only implement OBRA Section 9352(b), and not Section 1154(4)(A) of the Social Security Act.

AMPRA is concerned that HCFA's operational plan to implementing PRO after-care review is going to result in an approach that will be narrow in scope. We are of the opinion that an attempt is being made to construct a program, the goal of which is to meet a charge with little interest in any meaningful outcome. One can also question whether the approach truly addresses OBRA's intent of authorizing PROs to extend activities into the nursing home and home health care arenas. AMPRA is taking the liberty of outlining some approaches that might be considered if HCFA were to embark upon a more meaningful program. Additionally, AMPRA wants to raise the point that LTC PRO review, properly performed, could provide invaluable information to the survey, certification, and inspection of care processes that are being increasingly criticized as being inadequate. The material that follows is based upon existing PRO experience; experience which has produced some potentially useful procedures and criteria that are applicable to Medicare needs.

A major concern is that the limited HCFA approach simply fails to address issues of substandard non-hospital based care. A single trigger of 31 day hospital readmissions will probably not capture many instances of provable substandard after-care. Such a failure is not considered to be in the best interests of any of the participants. In our review experience, quality can best be impacted when a number of cases or profiles exist to base conclusions upon. AMPRA is fearful that a minimal system approach that stresses definitive corrective action on the basis of single case retrospective review is potentially unproductive and does not begin to meet Congressional intent. AMPRA urges the Finance Committee to use its best efforts to influence HCFA to critically re-evaluate the course that is being charted.

Constructively, AMPRA urges the acceptance of a reasonably controlled review program that includes components of both Retrospective and Concurrent Review. Methods must include a longitudinal data base, inasmuch as most LTC researchers and patient evaluators recognize the changing nature of gerontological disability and the necessity of this type of information to intelligent decision making. The review should rely heavily on outcome assessment on a meaningful sample that addresses clinical situations that are of high cost, high volume, and potential low quality. Acknowledging that the information should be and could be of use to the survey and certification process, this effort should avoid competitive review of the structural and process measures that are currently a part of survey activity.

The material that follows offers some thoughts that might be used in constructing an appropriate review system.

Retrospective Review:

Cases to be reviewed should initially include only individuals who are discharged from hospitals to SNFs and HHAs under the Medicare program. It might be wise to also consider a limited number of cases that are considered possible inappropriate admissions to the hospital from the SNF or ICF, these cases being identified through the standard PRO hospital review.

Review should be targeted toward a population that is at risk of high cost, high volume, and questionable quality care. Some possible indicators follow:

1. Deaths following hospital discharge.
2. Hospital readmissions that occur within 31 days or where two readmissions occur within six months of discharge.
3. RN Home Health Visits of more than 4 hours per day for more than 6 weeks.
4. Intensive Outpatient therapy for more than six weeks.
5. Nursing Home Length of Stay of over 3 months (new admits).
6. All transfers between nursing homes.
7. Hospital Emergency Room referrals.
8. Severity indexed patients (Approaches will be furnished upon request).
9. Family or Ombudsperson complaints.

If patient identifiers such as these were piloted in conjunction with an appropriate review instrument, a firm foundation for meaningful retrospective review data base would established.

CONCURRENT REVIEW

Recognizing that HCFA faces serious cost restraints, the issue of concurrent review needs to be reconsidered. AMPRA believes that the intent of Congress was to provide a system that follows patients through the health care continuum. We also believe that this is best accomplished through a system of concurrent review, and that it can be accomplished in a focused manner that does not consume an inordinate amount of fiscal resources (indeed experience may well indicate that funds can be saved by good programs). Finally, the ability to follow patients on-site is necessary to promote recognition of the program, educate the facilities and the programs to the program expectations, and to actually train reviewers as to what the situations really are in the field. Therefore, AMPRA urges the inclusion of a Focused Concurrent Quality Review and Assurance in this program. The material that follows presents a modest program that could be utilized to meet these and other goals (such as survey needs, investigation needs, and providing the potential for immediate interaction with the physician community when potential problems are identified). HCFA should be challenged to utilize PROs that are currently performing some form of LTC review to pilot this type of review. In addition, a scientifically designed evaluation including a suitable control should be utilized.

In designing such a program, the following basic steps are recommended:

1. The hospital discharge planner would identify sentinel diagnoses in patients where after-care is to be ordered. These diagnoses would include those conditions that carry high risk of significant deficits in function.

2. The hospital planner would then telephone the nurse reviewer at the PRO. A determination would be made at that point whether the patient was a candidate for ongoing Concurrent Quality Review. If so, a Functional Assessment would be conducted by the hospital using an agreed upon functional assessment instrument that is built on Activities of Daily Living (ADLs). A number of instruments are available, and an effort should be made to identify a specific approach for this program. This assessment would be included in the materials forwarded to the receiving program or nursing home.

3. The receiving facility would verify the assessment and report back to the PRO if there was disagreement. An attempt would be made to resolve the disagreement by telephone, or if not resolvable, an on-site assessment would be made by the PRO. In addition to assuring an accurate baseline such an assessment would be invaluable for immediate intervention if the patient was at undue risk or was considered as a premature discharge.

4. At periodic intervals, an on-site visit would be made by PRO reviewers to ascertain the ADL status and to determine if reasonable progress was being made on functionally based outcomes. I would propose using criteria such as those developed in the PSRO demonstration project in the late 70's.

5. Where defects in care were determined, the PRO would immediately notify the provider and attending physician to allow for input and correction. The information would also be available for profiling and further corrective action, if necessary.

It must be emphasized that geriatric and gerontological practice centers on a functional approach and not on the diagnosis or DRG code. People have to go into nursing homes because they cannot functionally cope or the necessary supports do not exist in the community. These factors are well known and the Institute of Medicine report stresses their importance. Any attempt to rely strictly on clinical diagnoses will fail and should be discouraged.

Going beyond the current dilemma as it relates to PRO review alone, it would be well to consider the overall issue of quality assurance in LTC in general. The Institute of Medicine Report in 1986 on nursing homes clearly addresses the overall problem. Quality assurance currently depends upon the Survey and certification programs. As you know, these programs have been judged inadequate and a new approach has been adopted (PACs). It is AMPRA's understanding that this approach is already being questioned. A major weakness in the PACs system in addition to the lack of longitudinal tracking is the absence of realistic review of physician care. The information collected under the program outlined would be an invaluable supplement to the actual periodic survey. Additionally, the issues of physician involvement would be more easily impacted by PRO review where physicians can deal with physicians on a doctor to doctor basis. In our opinion, quality in LTC will never by appropriate until the physician role is recognized, appropriately addressed, and disciplined where necessary. All of the other services are dependent upon intelligent medical management.

AMPRA appreciates the Committee's consideration of these issues, and would welcome the opportunity to discuss them further.

FAMILY SERVICE ASSOCIATION OF INDIANAPOLIS
POSITION STATEMENT REGARDING HOME-BASED SERVICES FOR THE ELDERLY

There is a generally recognized and rapidly growing need in our society to provide care for elderly citizens who are no longer able to live in self-care arrangements unassisted. Based on the values of our society in favor of self-responsibility, self-determination, independence, and freedom, the Family Service Association of Indianapolis supports programs that promote the least restrictive alternatives for the care of the elderly, consistent with safety, health, and well-being. A continuum of services to meet the individual and particular needs of elderly persons stands out as the most cost-effective, humane, and feasible approach to meeting this critical social need.

The experience of the Family Service Association shows that elderly persons who are no longer capable of total self-care tend to have multiple, interdependent needs, and that if one or more of these needs goes unmet, the others become more severe. Most elderly persons who need assistance suffer loss of self-esteem because of becoming dependent in the context of a society that values independence and in the context of their own history which in most cases is that of pride in their own self-reliance. Fear of deepening dependency and further loss of the ability to function independently is very common. The majority of elderly persons who need assistance have experienced significant losses: spouses, friends, neighbors, and even children have died. The mobility of our society has caused loss of proximity of family members and friends. Not the least of the losses is the loss and potential loss of independence, to say nothing of important bodily functions, such as hearing, sight, taste, and smell. It is the rule rather than the exception for these elderly persons to have lost intimate relationships in which they experience touch. Debilitating grief is a common emotion in this population. Some elderly persons grieve over the loss of their own youth, the loss of health, the loss of physical attractiveness or capacity for activity, and the loss of employability and productivity. Depression has very high incidence among the frail elderly. Dependency on alcohol or on medication is also a common problem.

Some elderly persons become embittered and angry about their circumstances and feel cheated or unfairly burdened by their condition. These feelings tend to further alienate these individuals from sustaining, supportive relationships.

Often, publicly supported services are sought in preference to familial or primary group resources. Many elderly persons do not wish to burden adult children or other relatives and friends, and do not wish to impose their needs on others. Thus they may not communicate their needs to those closest to them. Conversely, many adult children do not want to interfere, or imply that the aged parent is "failing" or inadequate. Thus, they do not offer to provide needed assistance even when they perceive the need. Sometimes, adult children of elderly parents are resentful of past parent-child problems, have detached themselves from the parent for their own well-being, and resist reinvolvement in painful relationships, e.g. with parents who were alcoholic and abusive, with a parent who sexually exploited the child, or with a parent who abandoned the child at a time of critical need, or failed to protect the child from others.

Many adult children are not in circumstances which allow involvement with an aged parent sufficient to meet the parent's needs. The likelihood is that both the adult child and his or her spouse are employed outside the home. Arranging adequate care for their children is a constant struggle. Typically, there is not enough space in the home of adult children to accommodate the addition of an elderly parent into the household without intrusion into the space of the children in the home. Guilt, frustration, and anxiety are prevalent emotions among the adult children of the elderly. Blame and resentment are common among adult siblings, particularly when one adult child lives in proximity to the aged parent, while siblings are too far distant to be directly involved in care-giving.

Unless programs for elderly persons address these multiple needs, our society is at risk of creating a new class of disadvantaged and isolated persons, imprisoned in their own homes with little contact with other human beings. The very programs which should maximize the potential for independent living arrangements and normal social relationships may, if they are not wholistic in their approach, actually increase isolation and cause deterioration in social functioning, with resultant high economic, social, and political cost.

The cornerstone of an effective, comprehensive, cost-efficient program of home-based services for the elderly is an individualized, in-home assessment. This assessment should be performed by a professional with specialized training and experience in work with the elderly. The assessor must have extensive knowledge of the availability of a wide range of available community resources. The assessor must be capable of negotiating with the client a plan of care, and must be able to engage the resources needed to put the plan of care into effect. Reassessment and updating of care plans must be done regularly, to ensure that the program appropriately responds to the client's changing condition and needs.

A comprehensive home-care program for the elderly should have a strong educational and preventive component. Group educational programs for adult children of aged parents can promote family involvement in providing needed services, and can help in building bridges of understanding and communication between the aged client and adult family members. Such programs can in many cases prevent the need for publicly supported direct care of the aged client. These programs can relieve much of the guilt, frustration, and anxiety felt by many adult children who do not know how to go about meeting the needs of an aged parent who cannot live alone unassisted, and who are often unfamiliar with community resources. A massive aging, urban population needing assistance outside the homes of family members is a relatively new phenomenon in our society. There is little in our socialization patterns that prepares people for coping with their own dependency or frailty in old age, and consequently even less that prepares children for assuming care-giving roles with aging parents. Families should be regarded as the primary resource for meeting the needs of frail elderly persons. An adequate assessment should determine the extent to which family members can feasibly be involved in carrying out certain elements of the care plan for the elderly client.

Another essential ingredient of a comprehensive home-based program of care for the elderly is that of social services. Social workers should be responsible for the assessment and reassessment of need, but can also be instrumental in negotiating family care when such plans are feasible but have not occurred without social service intervention and/or assistance. The social worker who has done the assessment is in the most favorable position to serve as the leader for the team of care-givers who may need to be engaged to carry out the care plan. The social worker is also the most appropriate team member to engage the resources in the community to meet the individual needs of a particular client. It is essential that professional counseling services be made available to clients of a home-based care plan, to remediate problems such as depression, loss of self-esteem, fear, grief, isolation, and anger which may have been identified at the time of assessment, or which make their appearance during the subsequent period of service. Some clients are able to resume self-care after a period of counseling. It is highly advantageous for the assessment, counseling, and team leader functions to be performed by the same person. Accountability is better preserved when one person rather than several is responsible for case supervision and monitoring. This pattern affords opportunity for the social worker and client to develop a relationship of mutual understanding and trust. It promotes simplicity in operation and avoids confusing the elderly client as to "who to call". Social workers can arrange specific training for elderly clients to enable them to remain active and independent when faced with specific functional losses such as failing vision or hearing. When and if the time comes for an aged client to be best served in an institutional setting, the social worker can help the elderly client and family members accept the necessity for this change, and can assist in making the transition as smooth as possible for all concerned.

Respite care is another critical element of a comprehensive program of services for the elderly. The quality of family life for the care-givers is protected from damage if the care-giver is periodically relieved of the relentless responsibility of care of a dependent individual. Likewise, some variety and expectation of adaptability and flexibility is maintained for the elderly client through a program of respite care. When the care-giver is an aged spouse, respite care is particularly important, to protect the care-giver from fatigue, and possible physical and mental deterioration. Respite care is another service that supports family members as the primary care-givers, and often prevents the need for more expensive, publicly supported services.

Obviously, an adequate program of home-care services for the elderly must provide a continuum of services including the availability of homemakers, home-health aides, skilled nursing care, and medical diagnosis, treatment, and supervision. Attention must be given to linking and coordinating the acute health care system, a comprehensive home care service delivery system, and the system of long-term institutional care. Such linkage and coordination requires a multi-discipline approach. Accessibility to adequate medical care is still lacking for many indigent frail elderly persons in our society, and is a problem that must be remedied if any alternative to institutional care of the elderly is to succeed. When the elderly person is not in need of acute medical care, nor of long-term institutional care, arrangements must be made for periodic physician review and monitoring. However, the physician typically has neither the skill nor the interest to identify the range of community resources which would be helpful to the client, to arrange for the client to receive these services, and provide follow-up contact to ensure that the services are actually provided. The social worker is probably the more appropriate team leader when home-based care is the plan of choice for the client.

It is also essential that the focus of governmentally funded programs include chronic, long-term, supportive, non-medical care. We believe that the cost-effectiveness of such programs can be readily documented. At the same time, it must be recognized that the comprehensive care described in this position paper is expensive. There is a substantial cost differential between this type of service and that typically provided by proprietary care-givers. The most common patterns of care currently rendered by proprietary organizations is that the client receives only the concrete service of a homemaker or home health aide, and that little or no attention is given to involvement of family members, referral to other needed resources, or inclusion of volunteer services, to say nothing of counseling for the problems of depression, fear, loss of self-esteem, addiction, and addiction identified elsewhere herein as critical problems and needs of this population. The more astute proprietary providers make referrals to counseling resources in the community for these services, but funding, coordination, and monitoring of such arrangements is difficult at best. Further, most proprietary providers employ their care-givers on a "contractual" basis and pay them only for the time actually spent in clients' homes. They often do not provide or pay for orientation, in-service training, or supervision. Most often, there are no fringe benefits such as medical insurance, retirement plans, paid holidays, sick leave, or vacation. We believe public policy should support provision of all such benefits for in-home care-givers, not only because they ultimately affect the quality of client care, but because care-givers themselves should not be put in the position of dependency on services for the indigent when they are confronted with extensive medical needs or when they retire. Such employee benefits account for a substantial cost differential between the common service patterns of proprietary providers and those providers which offer the comprehensive services described herein.

Homemakers are generally understood to be paraprofessionals who provide environmental services essential to the maintenance of living arrangements outside an institution, and short of full-time, live-in care. Such services include weekly cleaning, cleaning of bathrooms, doing laundry, changing beds, and other essential services which many frail elderly people are no longer able to perform themselves. Home health aides are persons trained to provide personal care and health care services as prescribed by a physician and provided under the direction of a nurse. Skilled nursing care must be available for those persons who need specific medical care and supervision outside a hospital. All services should be provided by persons qualified for their roles by appropriate education, experience, in-service training, and supervision. The standards of such national accrediting bodies as the Council on Accreditation of Services for Families and Children and the National HomeCaring Council of the National Foundation for Hospice and Home Care should define the measures of quality to which home-care programs for the elderly should conform.

Guardianship services should be available for those elderly persons who cannot make responsible decisions in their own behalf and who have little or no familial or financial resources to obtain this service. Other services that are essential to a well-functioning comprehensive care program include a variety of supportive services such as transportation programs, meals on wheels, emergency communication systems, etc. Nutrition programs, health education programs and services, programs to ensure safe and sanitary housing, income maintenance programs, and adequate medical services must be available and accessible to this population.

Additionally, an adequate home-based care system must recognize emerging new populations needing special attention and specialized services. For the first time in our history we have substantial numbers of old persons caring for the very old - people in their sixties and seventies caring for parents and other relatives in their nineties and beyond. Similarly, there is a growing group of developmentally disabled persons who have been cared for at home by their parents, who now have died.

All services need to be integrated into one care plan, and coordinated to the greatest extent possible. Insofar as possible, one provider should be responsible for multiple services, instead of multiple providers providing single services. A single standard of eligibility for all needed services should be established. The elderly client should not have to contend with multiple authorities to secure the needed service components, and providers should be able to be quickly responsive to needed changes in the care plan. The service system needs to be as simple and direct as possible. The current "categorical" care system does not contemplate the family as a totality or as a care-giving system which is recognized as a unit. This flawed perspective must be remedied if families are to be adequately served and if the public is to adequately benefit from the care that families can give to dependent persons.

Volunteers should be engaged in supportive, direct service roles with clients. Friendly visiting, telephone reassurance, and reading and writing correspondence are but a few of the services that can be provided by volunteers.

All services should have a family focus. That is, the service systems should recognize the context of the client's family and other primary relationships, and should not de facto isolate the client by focusing services on the client alone, apart from the client's family and social context.

The principles contained in this position paper regarding services to the elderly are equally applicable to other dependent persons, such as the mentally ill and the developmentally disabled, regardless of age, who do not require institutional care but who cannot live in self-care arrangements in the community unassisted.

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NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

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STATEMENT OF

FORMER CONGRESSMAN JAMES ROOSEVELT

CHAIRMAN OF THE NATIONAL COMMITTEE

TO PRESERVE SOCIAL SECURITY AND MEDICARE

SUBMITTED TO

SUBCOMMITTEE ON HEALTH

THE COMMITTEE ON FINANCE

U.S. SENATE

REGARDING

QUALITY OF LONG-TERM CARE

APRIL 28, 1987

Mr. Chairman, my name is James Roosevelt and I am the Chairman of the National Committee to Preserve Social Security and Medicare. In that capacity I represent more than four million members, most of whom are age 65 and older. Over the last few years, I have received hundreds of letters from National Committee members documenting nursing home abuses and calling for nursing home reform. The federal government has neglected its responsibility to ensure that nursing home residents receive quality care. The government has been reluctant to use all of its possible weapons, especially effective enforcement measures such as fines. Except for an underfunded ombudsman program, the government has given senior citizens and their families little assistance in finding a good nursing home and protecting their rights. It almost appears that Medicaid and Medicare condone neglect and abuse in our nation's nursing homes.

Senior citizens and their families are looking to the historic 100th Congress to reform our nation's nursing homes. For example, no nursing home resident should have to lie in his or her own waste and urine for hours or be strapped to a chair for wifht or ten hours a day. All nursing homes should be held accountable for treating their frail residents with the respect and dignity they deserve as our mothers and fathers. I want to thank you, Mr. Chairman, for holding this hearing and committing yourself to nursing home reform.

Introduction

Nursing home residents are one of the most vulnerable segments of our society. The humanity of our society will be judged by the way we treat the most vulnerable in our society. Over 1.5 million seniors currently reside in nursing homes. While this is only 5 percent of older Americans, 20 percent of older Americans are at risk of needing nursing home care sometime before they die. The burden of care has overwhelmed the private capacity of families to care for their loved ones at home or to pay for nursing home care. Society must help with this burden. The National Committee recommends that any catastrophic health insurance initiative adopted by Congress include coverage for long-term nursing home care. Unfortunatley, the quality of long-term care already provided is also lacking.

In the July, 1985, issue of Saving Social Security, we requested readers to describe, in writing, their first-hand experiences with the quality of nursing home care. Relatives and friends of nursing home residents, residents themselves and a few former and present nursing home employees documented numerous instances of nursing home abuse. My staff prepared a report entitled Please Don't Publish My Name: A Call For Nursing Home Reform, which we plan to release very soon.

Many members who wrote expressed helplessness, hopelessness and bitterness. One woman, referring to her sister, writes, "She was let out to come home, at her own request, and committed suicide rather than go back. I plan to do the same thing when my time comes." Another simply wrote, "I too will end it all before

I go back to one."

A Woodland Hills, California, woman wrote a list of nine cases of neglect and abuse that her husband had suffered in a nursing home. For example, "The aide taking care of him punched him on the head (where it wouldn't show) because the aide assumed my husband had removed his catheter and now the aide had to change the bed." Another example: "My husband could not feed himself due to paralysis from a stroke; the aide shoved food into his mouth so fast my husband couldn't swallow or chew it, and after choking several times, refused to eat."

In response to the concerns raised in these letters, the National Committee developed a five point plan calling for:

1) strong federal penalties;
2) quality of care surveys;
3) effective training of nursing home personnel;
4) a stronger Long-Term Care Ombudsman Program; and
5) a rating system to help consumers to select a good facility.

These five points offer a broad outline to revamp the nursing home industry in a way that would be more responsive to the needs of residents and their families. Last year, you heard from tens of thousands of National Committee members who wrote to Congress asking for support of our five point plan.

Stiffer Federal Penalties

"It is your tax money and mine," wrote one respondent, "that is paying for this treatment of our sick and elderly. Right here in our own country are the most neglected and abused people in the world and we are condoning it through Government funds." Nursing homes can continue to receive payments for care even if they violate the most basic of patient rights, because patient rights are not even a "condition of participation" for Medicare and Medicaid.

Until recently, federal sanctions were totally unrealistic. If a nursing home was out of compliance, the only sanction available was stopping payment completely. This would have the effect of closing-down a nursing home and requiring a transfer of patients, a penalty almost as harsh for the residents. Federal regulators were understandably reluctant to impose such a drastic sanction unless the conditions were severely deficient. One alternative to stopping payment would be to put a chronically substandard nursing home into government-managed receivership.

The Health Care Financing Administration has finally implemented one intermediate sanction, a ban on admissions. Since the nursing home is given several months to correct the problem, this sanction does not insure that the improvements are either immediate or permanent. Civil fines, imposed at the time of the infraction and of variable severity depending on the frequency and severity of infractions, would not only result in the correction of deficiencies, but would also greatly reduce the chance of reoccurrence.

Quality Surveys

Many studies as well as federal court cases have documented the inadequacies of the federal survey process. A good survey boils down to two things. First, surveyors should look at the quality of life in a nursing home through the eyes of nursing home residents themselves. Second, a survey should reflect normal conditions in the nursing home, not a special effort to impress the surveyors. Our respondents had similar ideas, like the one who suggested, "Inspectors should go to those nursing homes - pose as a relative and check around and spend an hour or so with someone. Press the button on the bed and see how long it takes for a nurse to come in. They'll learn a lot in a short time." Another respondent asks rhetorically, "Why should a home be notified that an inspection is coming? They say they don't know when the state will come. But believe me if you could see the cleaning going on a few days before an inspection, you would know better."

Unlike survey and certification regulations of the past, the new regulations should not just focus on a facility's capacity to provide services but also on the quality and appropriateness of care received. Quality of care and quality of life levels should be measured through a standardized survey focused on key quality indicators. This survey should be developed by the Health Care Financing Administration.

Training of Nursing Home Personnel

The vast majority of care given in nursing homes is given by nurses' aides. Yet, a qualifying examination for nurses' aides is required in only 17 states. This is a deplorable situation and should be rectified. A man from Beaumont, Texas, whose wife was institutionalized, wrote: "Employees not properly trained to handle patients with a mechanical lift dropped her twice - once from almost three feet, head first on the tile floor. It took three stitches to close the bursted scalp. The other time, I saw it coming and threw my arms and legs under her to break the fall."

Our members proved themselves very astute in understanding the problems in training competent nurses' aides. As one member wrote, "I know these aides get minimum wages. As soon as they find somthing better, they leave. These aides are the contacts with those poor souls - yet there are always new faces instead of familiar, caring ones."

We urge you to include a comprehensive and mandatory training program in any legislation that you are considering. But in order to attract competent nurses' aides, nursing homes will have to offer better wages and the Medicare and Medicaid reimbursement structure needs to recognize this.

Strengthened Long-Term Care Ombudsman Program

Even in a good nursing home, residents need help in solving individual problems. Congress established the Long-Term Care Ombudsman Program to help residents protect their rights without fear of retaliation. The ombudsman, however, frequently does not have the resources, the authority or the legal protection to fully carry out his responsibilities. Our members frequently complained about the inability to resolve their problems. "I knew they were abusive, but I didn't know where to turn. I was afraid that if I complained too much they would treat him even worse," one said.

Congress must provide ombudsmen free and unhindered access to all facilities, residents and records deemed necessary for proper care and free ombudsmen from legal liability for actions in exercise of their official responsibilities. Senator Glenn recently introduced legislation, S.959, which would implement the National Committee's recommendations regarding the Ombudsman Program. Ombudsmen should also be looked to as an "early warning" signal that a nursing home is providing substandard care.

Nursing Home Rating System

Even after considerable research, our members reported that they frequently could not find a good nursing home. One letter begins, "My husband was in what was considered a 'better' nursing home for six months. It was the most miserable experience both of us ever had." Another letter from Ontario, Oregon, ends, "I would leave here but doubt if I could better myself. I have been told this is the best in the city." One husband, after suspecting that his wife was being sexually abused in one nursing home, took her home while searching for a better home. He subsequently found a good, caring facility where the wife received excellent care.

If seniors had a nursing home rating system in their area, many of the problems our members encountered may have been avoided. Many families are not in a position to do extensive research to locate a good nursing home. When a person enters directly from the hospital, there frequently is not enough time to do the necessary research. A rating system also recognizes the good performance of many nursing homes.

Consumers depend on rating systems for goods and services produced by other industries such as motels, restaurants, cars, insurance plans, etc. The State of Illinois, for example, recently started a government-sponsored rating system which is working. In addition to applying a four-star rating system, Illinois further motivates nursing homes by paying cash to the facility for each earned star. The National Committee recommends that the Department of Health and Human Services develop a rating system for nursing homes, preferably based on the standardized quality care survey used to inspect nursing homes.

Conclusion

The need for effective and comprehensive nursing home reform is critical and immediate. The Institute of Medicine last year released a report, Improving the Quality of Care in Nursing Homes. The report confirms widespread nursing home abuses and makes a number of recommendations for nursing home reform. Too often, however, government-sponsored reports gather dust and no one takes action. National Committee members are committed to not seeing this happen.

In addition to the National Committee's five point plan, we have collaborated with the National Citizen's Coalition for Nursing Home Reform and other national organizations in the development of 12 position papers primarily based on recommendations from the Institute of Medicine study. We presented these recommendations to Congress in a press conference last Friday. These position papers more fully detail our legislative recommendations and advocate a prohibition of discrimination against Medicaid patients and the promotion of social and mental health services. We urge you to implement these recommendations.

I know, Mr. Chairman, that you care deeply about the health and welfare of America's senior citizens. I am sure that you and other Members of Congress will do everything possible to ensure that the care that the frail elderly receive in nursing homes will be of the highest quality. With a doubling of the nursing home population in the next twenty years, the problem will only grow worse, unless Congress acts now.

Thank you.

Printers

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NASW

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May 28, 1987

Mr. Bill Williams
Staff Director
Senate Finance Committee
205 Dirksen Senate Office Building
Washington, D. C. 20510

Dear Bill:

It was a pleasure speaking with you today about placing our testimony on the record for the April 28 hearing on nursing homes and home health. We are glad that you are still able to include this on the record at this date.

Thanks again for your consideration.

Sincerely,

Sue Hoechstetter

Susan Hoechstetter, ACSW
Legislative Affairs Manager

The National Association of Social Workers (NASW) represents 105,000 members and is dedicated to improving social conditions and the lives of individuals and families in this country. As such, NASW is supportive of consideration and action being taken by members of the Senate Finance Committee in the 100th Congress to improve the quality of care provided to nursing home residents. Our testimony is focused on the psychosocial needs of nursing home residents and overcoming barriers to meeting those needs.

Individuals living in nursing homes face a variety of emotional and social stresses which affect their quality of life and their ability to function at an optimal level. These psychosocial stresses may interfere with the resident's medical treatment plan. Separation from family and other loved ones, a radically altered personal living situation, isolation from community resources, financial stress, an alien living environment, and emotional or mental problems that sometimes accompany the aging process itself are just some of the realities with which they must contend. It is estimated that close to two-thirds of all nursing home residents have a diagnosed mental disorder. With hospitals discharging patients "sicker and quicker" to comply with DRG regulations, more individuals with greater medical and psychosocial needs find themselves looking to long-term care facilities as alternative-living situations.

SOCIAL WORK SERVICES IN THE NURSING HOME

The role of the social worker in a nursing home is to provide services designed to identify and meet the social and emotional needs of each resident; to assist each resident and their family to adjust to the effects of their illness or disability, treatment, and stay in the facility; to maintain or establish appropriate linkages for residents to community social and health resources; and to assure adequate discharge planning. Specific social work service functions in a nursing home generally include, but are not limited to:

- direct counseling services to residents, families and groups at the time of admission and throughout the placement as required:
- advocacy;
- community liaison and linkage to services;
- development of a therapeutic environment in the facility;
- consultation to members of the health care team;
- working with resident and/or family councils;
- securing resources and working with community volunteers and other community agencies and organizations;
- participation in policy development and program planning;
- discharge planning.

Social work services can offer an improved quality of life for residents and can contribute to a facility's work to contain costs. "Qualified social workers deliver social services in a manner that is effective for residents and that, in the long run, is also cost-effective," according to Jenean Erickson, Administrator of the Yorkshire Manor Nursing Home in Minneapolis, Minnesota. Ms. Erickson, a nurse by training, employs professional social workers to deliver social services in her facility.

Data suggests that people under emotional stresses are higher users of medical treatment than others. Social workers in nursing homes are in critical positions to help ease those emotional stresses and thereby, reduce medical costs. As an American Psychological Association summary of a Kaiser-Permanente study (Cummings and VandenBos, 1981, Health Policy Quarterly, p. 1) found:

> A series of studies have been conducted since the inception of mental health care coverage, and all concluded that psychological intervention can be cost effective by saving on medical costs and therapeutically effective.

CURRENT BARRIERS TO THE EFFECTIVE DELIVERY OF SOCIAL SERVICES

Despite the critical need for the effective delivery of social work services in nursing homes, a large number of residents are not receiving those services. The major obstacle is the lack of strong requirements. The result, as documented by the Institute of Medicine's 1986 Report Improving the Quality of Care in Nursing Homes, is uneven and inadequate availability of social services.

The current social service condition of participation for a skilled nursing facility allows the facility to either refer patients in need of social services to outside social agencies or to offer the services in the nursing home. If services are offered in the nursing home, a designated staff person is responsible for social services. The designee is required only to consult with a qualified social worker or social agency. The Institute of Medicine's report found:

> Reliance on this weak requirement has produced uneven results at best. Studies in various parts of the country show that many facilities have a bare minimum of social services--that is, they hire an MSW for 4 hours per month of consultation and appoint designees who are less than full-time and have little professional or even general education. Studies of the consultant role have shown how difficult it is for a nursing home consultant to design a social work program, develop procedures for a socially and psychologically sensitive environment, train and supervise social service designees, and design and conduct in-service training for all nursing home staff, given the minimal time allotted to their role and their negligible authority as a consultant.

The State of Texas' Long Term Care Coordinating Council for the Elderly (comprised of representatives of the nursing home industry, consumers, educators and Texas Department of Health staff,) concurred in their March 25, 1987 issue paper Social and Emotional Needs of Residents of Texas Nursing Homes, that social services staffing patterns are often inadequate. After reviewing social work treatment concepts in nursing homes, they found that:

> It is also clear that, when considered in the context of Texas nursing homes, most models cannot be fully articulated due to parsimonious funding and the lack of qualified professional staff. Without qualified staff's knowledge and skills in treatment program design and delivery, a limited repertoire of approaches, the proverbial activities of bingo, Bible, and birthday parties, are offered to the many and slightly enriched, but still meager treatment menu consisting primarily of psychotropic medications is offered to the few with extreme behavior problems or strident needs. The exception may be the situation that obtains in a small number of non-profit nursing homes that employ sufficient, qualified social service staff.

RECOMMENDATIONS

To eliminate barriers to the effective delivery of social work services in nursing homes in order to enhance quality of life for residents, in a cost effective manner, NASW recommends that:

- Each long-term care facility with 80 beds or more be required to employ at least one full-time professionally qualified social worker per 80 beds to assure the provision of appropriate social services.
- Each long-term care facility provide social services which include at least: planning for preadmission and discharge; providing psychosocial assessment at periodic intervals; care planning; counseling and other

psychotherapeutic services; developing and utilizing community resources (care coordination); assisting in the preservation of family and other social relationships; promoting visitation to residents; maintaining community ties; working with other nursing home staff to facilitate residents' adjustment to the facility; advocating for residents' rights; and promoting understanding of each resident as an individual.

CONCLUSION

NASW commends Senator Mitchell and his colleagues for their work in drafting and introducing the "Medicare and Medicaid Nursing Home Quality Care Amendments of 1987." This legislation proposes conditions of participation for nursing homes under titles XVIII and XIX of the Social Security Act which would improve the quality of resident care enormously. It is particularly satisfying to see the recognition of the need for psychosocial resident assessments in the bill, as well as language to improve patients rights and nursing and social work services requirements. Improvements such as these are critical if we as a society want to see all nursing home residents actually receive the quality care they deserve.

Attached is NASW's position paper on Home Health. We wish the Committee to consider this paper as testimony in relation to S. 1076, the "Medicare Home Health Services Improvement Act of 1987."

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